

*2003 State of Maryland
Summary of Health Benefits for*



MARYLAND STATE EMPLOYEES

*Important Benefits Information for Year 2003
Read This Booklet Carefully & Completely*

*Open Enrollment Dates:
November 11 – December 6, 2002*

CALL: IVR (410) 669-3893 or 1-888-578-6434
*Automated Telephone Enrollment, 24 hours a day,
7 days a week during Open Enrollment.*

*For Benefits Fair information, visit our website:
www.dbm.maryland.gov*





NOTE: The Term Life Insurance Plan is with Standard Insurance Company effective January 1, 2003.

Premium Rates for Term Life Insurance Effective January 1, 2003

Age of Employee	Bi-Weekly Employee Rate (per \$10,000)	Monthly Employee Rate (per \$10,000)	Age of Spouse	Bi-Weekly Spouse Rate (per \$5,000)	Monthly Spouse Rate (per \$5,000)
Under 20	.29	.58	Under 20	.31	.62
20 to 29	.29	.58	20 to 29	.31	.62
30 to 34	.35	.70	30 to 34	.34	.68
35 to 39	.46	.92	35 to 39	.42	.84
40 to 44	.72	1.43	40 to 44	.62	1.24
45 to 49	1.16	2.32	45 to 49	.96	1.92
50 to 54	1.88	3.75	50 to 54	1.44	2.87
55 to 59	3.24	6.48	55 to 59	2.23	4.45
60 to 64	4.68	9.36	60 to 64	3.41	6.82
65 to 69	6.99	13.98	65 to 69	4.96	9.92
70 to 74	12.51	25.02	70 to 74	7.80	15.60
75 to 79	24.47	48.94	75 to 79	7.80	15.60
80 and older	24.47	48.94	80 and older	7.80	15.60

Dependent Child Coverage is .95 per \$5,000 per month



NOTE: The AD&D plan is with the Metropolitan Life Insurance Company effective January 1, 2003.

AD&D Plan Rates Effective January 1, 2003

Plan Coverage Level	Employee Only Biweekly	Employee + Family Biweekly	Employee Only Monthly	Employee + Family Monthly
\$100,000	\$ 0.90	\$ 1.65	\$ 1.80	\$ 3.30
\$200,000	\$ 1.80	\$ 3.30	\$ 3.60	\$ 6.60
\$300,000	\$ 2.70	\$ 4.95	\$ 5.40	\$ 9.90



NOTE: There is a dependent verification audit after Open Enrollment. If you added a new dependent during open enrollment, you will be required to produce documentation to verify eligibility for the new dependent. Ask your Agency Benefits Coordinator about this requirement. If you attempt to add an ineligible person to your coverage, or if you fail to remove a dependent who is no longer eligible, you will be required to pay the full Individual premium for the ineligible person from the date such coverage becomes effective until it is terminated.

COBRA NOTICE TO EMPLOYEES AND THEIR DEPENDENTS

The State Employee Health Benefits Plan is covered by the Public Health Service Act (PHSA) and the provisions of the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) which are included in the PHSA. The Plan is not covered by ERISA. An employee and/or their eligible dependents may elect to continue certain group benefits, if coverage is lost due to termination, resignation, layoff, loss of dependent status, death, divorce or legal separation. These COBRA benefits may continue for a timeframe determined by COBRA regulations. Please see the COBRA section of this booklet for further information on COBRA. Employees and dependents should notify the Employee Benefits Division within 60 days of a qualifying event to qualify for COBRA, for such qualifying events as divorce, a dependent ceasing to be eligible, becoming disabled within 60 days of COBRA coverage, etc.

SUMMARY OF MARYLAND STATE EMPLOYEES HEALTH BENEFITS 2003

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ENROLLMENT INSTRUCTIONS



ENROLLMENT INSTRUCTIONS FOR YEAR 2003 BENEFITS

1. Educate yourself on your Benefits Plan Options.

- Carefully Review the information in this book on each of the plans available to you.
- Call the benefit plan for further information and to request plan literature.
- Attend a benefits fair and speak to plan representatives.
- Contact your Agency Benefits Coordinator for further information.

2. Determine if you need to make enrollment changes or selections by using the Interactive Voice Response System (IVR) for:

- Enrolling in a new plan for the first time.
- Cancelling or making a change to your existing plans or coverage levels.
- Enrolling in Health Care or Day Care Spending Account for Year 2003.

If you do not enroll in a Health Care or Day Care Spending Account for Year 2003, you will not have a Spending Account in Year 2003.

3. You must use the IVR system for your Year 2003 Open Enrollment selections. The IVR system allows you to make enrollment selections through a touch-tone telephone (see page 3 for instructions).

- Review the following page on how the IVR system works.
- You will receive an IVR pamphlet and Benefits Statement from your Agency Benefits Coordinator.
- Review the IVR pamphlet for tips on how to use the IVR system to select your Year 2003 benefits.
- Review the IVR Benefits Statement before making your IVR call.
- If you have any questions on the IVR system or you need assistance to use the IVR, please see your Agency Benefits Coordinator.

4. If you use the IVR for your Year 2003 benefit selections, you will receive a Summary Statement of your Year 2003 benefit selections, confirming the time and date of your call.

NOTE: You must make your enrollment selections and changes through the IVR by the end of Open Enrollment. Do not send in Enrollment Worksheets. Once you make your selections, they are binding until January 1, 2004 unless you have a qualifying change in status.

NOTE: If you add dependents during Open Enrollment, you must supply your Agency Benefits Coordinator with proper documentation (see Required Documentation for Dependents) within 30 days of the date of your IVR call. If you do not supply your Agency Benefits Coordinator with these documents by the deadline, your dependents will not be covered. Even if you receive a membership card, your dependent will not be covered.

NOTE: Visit us at our website: <http://www.opsb.state.md.us/empbenefits/benefits.htm>.



Interactive Voice Response (IVR) Enrollment For Year 2003 Benefits

ENROLLMENT INSTRUCTIONS

**Call 410-669-3893 or 1-888-578-6434
24 hours a day, 7 days a week during Open Enrollment**

- During Open Enrollment for Year 2003 benefits, you will use the Interactive Voice Response (IVR) system to enroll, make changes to your benefits, and add or delete dependents.
- The IVR is an automated telephone enrollment system. You will call the IVR using a touch-tone telephone.
- The IVR will be available 24 hours a day, 7 days a week during Open Enrollment.
- For Open Enrollment, you will receive a personalized Benefits Statement. The Statement will contain pre-printed information about yourself and benefits coverage for Year 2003. Please review the Statement carefully before making your telephone call.
- You will also receive an IVR pamphlet. The IVR pamphlet will give you tips and instructions on how to use the IVR. Read through the IVR pamphlet carefully before making your telephone call.

GET READY TO CALL:

- After you have read your IVR pamphlet and completed your Benefits Statement, you are ready to call!
- Have your Benefits Statement and IVR pamphlet with you next to your telephone when you make your call.
- Call 410-669-3893 or 1-888-578-6434.
- The IVR automated attendant will then guide you through the system for Medical, Prescription Drug, Dental, Personal Accident and Dismemberment, Spending Account, Life Insurance, and adding and deleting dependents.
- After each and every selection you make, the IVR automated attendant will confirm what you selected. You will then be able to confirm this selection or cancel it right then and make a different choice.
- If you need to add a dependent(s), delete a dependent(s), or make changes to a dependent(s) information (such as their Social Security Number), you will also be able to do this using the IVR.

The IVR automated attendant will ask you to Speak and Spell your dependents' name:

-- You will first Speak the name of your dependent (First Name, Middle Initial, Last Name). Please speak slowly.

-- You will then Spell the name of your dependent (First Name, Middle Initial, Last Name). Please spell clearly.

- The IVR will then ask you to provide various information about your dependents, such as their Date of Birth and their Relationship to you. Do not use the touch tone pad for numbers. You must speak the number to be recorded.
- If you need assistance using the IVR, contact your Agency Benefits Coordinator in your Personnel Office.
- An updated Summary Statement of Benefits will be sent to you through your Agency Benefits Coordinator within 10 days after your IVR telephone call. The Summary Statement will list what benefits you have chosen for Year 2003, and confirm the date of your IVR telephone call.
- As the IVR is available 24 hours a day, 7 days a week during Open Enrollment, you can make further changes using the IVR throughout Open Enrollment.
- Although the IVR is available 24 hours a day, the best time to use the IVR is during the **non-peak hours of late evening to early morning.**

NOTE: It is also best not to wait until the last few days of Open Enrollment, when you may have a greater chance of getting a busy signal. Make your changes early. Once you receive your Summary Statement, please review it carefully. If an error has been made, you can go through the IVR and make the correction.



OVERVIEW OF PLANS



OVERVIEW OF PLANS

The State of Maryland offers its employees a wide range of health benefits. Please review the following descriptions of coverage carefully to choose the types best suited to your needs. This information is intended only as a general overview of available options. If you require specific information about coverage, limitations, exclusions, participating providers, or preauthorization requirements of the various plans, you must contact the plans directly. Each plan has dedicated service representatives that handle State employees' and retirees' accounts. The plans' service representatives have the most current information available to assist you with any questions you may have about their plans' coverage. Plan phone numbers and websites are located on the back cover of this book.

Cafeteria Plan: The State offers employees a cafeteria plan under Section 125 of the Internal Revenue Code. A cafeteria plan is an employer-provided health benefits plan which offers employees the opportunity to choose among non-taxable and qualified benefits. Qualified benefits are nontaxable benefits such as medical or dental coverage. If you choose to enroll for coverage for qualified benefits, the amount you pay for premiums is tax-free. It will not be included in your gross income for the plan year. The following available benefits are qualified benefits:

- Medical
- Prescription
- Dental
- Mental Health/Substance Abuse
- Term Life Insurance up to \$50,000 for employees. (Higher coverage levels are taxable.)
- Accidental Death & Dismemberment Plan (AD&D)
- Flexible Spending Accounts

Please note that there are benefits available that are not tax-free, such as term life insurance for dependents or for employee amounts over \$50,000, long term care premium deductions, and premium deductions for retirees for all plans.

NOTE:

- **Vision benefits are included under your medical plan coverage. If you are not enrolled in a medical plan, you do not have vision benefits.**
- **You must be enrolled in a dental plan to have dental benefits.**
- **CareFirst Blue Cross Blue Shield has replaced Freestate HMO with Blue Choice HMO effective January 1, 2003. If you are enrolled in Freestate HMO in 2002, you will be automatically enrolled in Blue Choice effective January 1, 2003, unless you make a change during Open Enrollment.**
- **There will be a new life insurance plan effective January 1, 2003. See the "Term Life Insurance" section.**
- **There will be a new AD&D plan effective January 1, 2003. See the "Accidental Death & Dismemberment" section.**
- **If you move and/or live out of State, please contact the medical plans and dental HMO plan(s) to confirm that the plan(s) service your area. If the medical plan and/or dental HMO plan does not service your area, you must select a plan which does provide service.**

Additionally, you will receive a Summary Plan Description from your plan after you enroll, giving you a detailed listing of coverage, limitations, and exclusions that are specific to your plan. This booklet is not a contract. The terms set forth in the contract shall prevail.



OVERVIEW
OF PLANS

PLAN TYPE	BENEFITS IN THE YEAR 2002
Medical Plan	<p>2 Preferred Provider Organizations (PPO) Plans 3 Point-of-Service (POS) Plans 3 HMO Plans All medical plans include vision benefits No dental benefits or prescription benefits are included in any medical plan.</p> <p>CareFirst Blue Cross Blue Shield has replaced Freestate HMO with Blue Choice HMO effective January 1, 2003. If you are enrolled in Freestate HMO in 2002, you will be automatically enrolled in Blue Choice effective January 1, 2003, unless you make a change during Open Enrollment.</p>
Prescription Plan	Prescription drug coverage.
Dental Plan	<p>Three dental plan options: two Dental Health Maintenance Organizations (DHMO), or a Dental Point-of-Service (POS) plan. No dental benefits are included in any medical plan.</p>
Mental Health/ Substance Abuse Plan	Coverage for treatment of mental health and substance abuse.
Term Life Insurance	Up to \$50,000 in coverage without Medical Review. Up to \$300,000 in coverage with Medical Review. Coverage also available for dependent(s). There is a new Life Insurance plan effective January 1, 2003.
Accidental Death & Dismemberment Insurance	Lump sum payment if you suffer dismemberment or death due to an accident. There is a new Accidental Death & Dismemberment plan effective January 1, 2003.
Flexible Spending Accounts	Tax-free reimbursement accounts for eligible expenses for either medical coverage or day care of eligible dependents.
Long Term Care	Coverage for Nursing Home Care, Assisted Living Care, Adult Day Care, etc., for covered members with Activities of Daily Living (ADL) certified disabilities.

Plan Descriptions: All Plan descriptions in this book adhere to a similar format and include sections on:

- **General Description of Plan**
- **How to Receive Plan Benefits**
- **Questions?**
- **Plan Benefits Chart**

Please refer to these sections to find the information you need. We have also included a glossary and index to further assist you in finding health benefits information in this book.

MEDICAL PLANS

General Description of Coverage

Medical coverage is available to all individuals and their dependents who are eligible for health benefits with the State. There are three types of medical plans offered: Preferred Provider Organization (PPO), Point-of-Service (POS), and Health Maintenance Organization (HMO). While all three types of plans offer comprehensive coverage, the type of medical plan you choose determines your premium, out-of-pocket expense, and choice of physician. Please remember that any medical treatment must be considered a "medical necessity" by your plan in order for payment to be authorized. The following chart gives a general overview of the differences in types of plans.

Choices in Medical Coverage

Type of Plan	Basic Format	Premium	Choice of Physician	Copay	Out-of-Network
PPO <ul style="list-style-type: none"> Carefirst Blue Cross Blue Shield MLH Eagle 	May choose any physician, but choice determines out-of-pocket expense.	Highest premium	Any PPO or Non-PPO physician at time of service. No need for plan referral to a specialist.	PPO Physician: \$15 Primary Care \$20 Specialist Care	Out-of-Network services subject to a deductible and 20% coinsurance.
POS <ul style="list-style-type: none"> Aetna Quality QPOS Carefirst BCBSM Maryland POS M.D.IPA Preferred 	A Managed-Care In-Network plan with the option to choose an Out-of-Network physician, subject to a deductible and 20% coinsurance. Must live within service area.	Lower Premium	Must choose a Primary Care Physician. Referrals required for most services to receive full In-Network benefits.	In-Network: \$5 Primary Care \$10 Specialist Care	Out-of-Network: May choose any physician at time of service, but such service is subject to a deductible and 20% coinsurance.
HMO <ul style="list-style-type: none"> Blue Choice Kaiser Optimum Choice 	Must choose a Primary Care Physician and receive all services from this physician. Your Primary Care Physician will refer you for Specialist Care if necessary. Must live within service area.	Lowest Premium	Primary Care Physician must pre-authorize all care.	\$5 Primary Care \$10 Specialist Care	No coverage for Out-of-Network services.



MEDICAL





MEDICAL



MEDICAL PLAN HIGHLIGHTS

BLUE CHOICE HMO

CareFirst Blue Cross Blue Shield has replaced Freestate HMO with Blue Choice HMO effective January 1, 2003. If you are enrolled in Freestate HMO in 2002, you will be automatically enrolled in Blue Choice effective January 1, 2003, unless you make a change during Open Enrollment.

VISION BENEFITS AVAILABLE ONLY THROUGH YOUR MEDICAL PLAN

If you want to have vision benefits in Year 2003, you must be enrolled in a medical plan in Year 2003. If you are not enrolled in a medical plan in Year 2003, you will not have vision benefits.

DENTAL BENEFITS AVAILABLE ONLY THROUGH DENTAL PLANS

If you want any dental benefits in Year 2003, you **MUST BE ENROLLED** in one of the three available dental plans.

If you are not enrolled in one of the three available dental plans for Year 2003, you will have no dental benefits.

PRESCRIPTION BENEFITS AVAILABLE ONLY THROUGH THE PRESCRIPTION DRUG PLAN

How to Receive Medical Plan Benefits

Once enrolled in the plan of your choice, you will receive identification cards in the mail. Take these cards with you every time you receive medical services. Depending on what type of medical plan you choose, the way you receive medical services and how much you pay at the time of service will vary. It is your responsibility to select the benefits plan that best suits your service and financial needs.

There are no pre-existing condition clauses for any of the medical plans, but there are other exclusions. Please contact the medical plans for further information on coverage exclusions, limitations, determination of medical necessity, preauthorization requirements, etc.

NOTE: All claims must be submitted within one year of the date of service. This includes resubmission of rejected claims.

Preferred Provider Organization (PPO): This plan allows you to choose any doctor you want at the time of service. Simply present your card to the provider. If your doctor is a participating physician in the PPO network, you will pay a copayment at the time of service. The copayment will be \$15 for a Primary Care Physician, \$20 for a Specialist.

If the doctor is not a participating PPO physician, you may have to pay the entire fee at the time of service and submit a claim for consideration. This amount will be applied toward your deductible (\$250/individual, 500/family). After you have reached your annual deductible, your PPO plan will pay 80% of the plan's allowed amount. You are responsible for the remaining 20% as well as any fees above the plan's allowed amount.



If you receive services from a non-participating physician, you may end up paying more than the plan's allowed amount. For example, if you receive services from a non-participating provider who charges \$1500 for service, but the plan only allows \$1000 for that service, you are responsible for the difference.

Actual Charges:	\$1500 Amount non-participating provider charges for service -\$ 500 (Plan Reduction) Member liable for this cost
What your plan covers:	\$1000 Plan's allowed amount for this service -\$ 250 Annual Individual Deductible paid by you for using a non-participating provider
	\$ 750 Plan pays 80% of allowed charges -\$ 150 20% coinsurance paid by you
	\$ 600 Amount plan will pay after all deductibles and copayments have been paid

What you owe to non-participating provider: \$ 900

Point-of-Service Plan (POS): This plan is a Managed Care or Health Maintenance Organization (HMO) type plan for In-Network benefits, with the option to choose Out-of-Network services without referral from your Primary Care Physician. You must choose a Primary Care Physician for all In-Network Services. When you use your In-Network benefits, receiving care from your Primary Care Physician, you only pay the required copayment at the time of service. The copayments are the same as those for an HMO -- \$5 for Primary Care and \$10 for Specialists.

You also may choose to receive treatment Out-of-Network without getting preauthorization from your Primary Care Physician. This is called "self-referral." This POS option gives you the freedom to choose your own provider, subject to a deductible and 20% coinsurance. Simply present your card to the provider. You will have to pay the bill at the time of service, but it will be applied toward your Out-of-Network deductible (\$250/individual, \$500/family). After your deductible has been met for Out-of-Network services, the plan will pay 80% of the plan's allowed amount for the services. You pay the remaining 20% to the provider as well as any fees above the plan's allowed amount.

Health Maintenance Organization (HMO): This plan offers the lowest premiums and copayments of the three types of medical plans. If you enroll in this plan, you must choose a Primary Care Physician. Choose carefully, because you will receive all of your medical services from this provider. When you receive services In-Network from your Primary Care Physician, you will pay a \$5 copayment. If your Primary Care Physician and plan authorize care from a Specialist, your copayment will be \$10.

Not ALL participating physicians are listed in books provided by the plans. Please call the plan to find out if that physician participates in any of the plans offered. Do not rely on the physician's office for current information. Please see the back of this booklet for Plan Phone Numbers and website information.

NOTE: The State cannot guarantee the continued participation of a particular provider in any of the benefit plans. Providers or the plan have the ability to terminate their association with a plan. If your plan physician chooses to discontinue participation in the plan, is terminated from the plan, or has chosen to close their panel to new patients, you will not be allowed to change your plan until Open Enrollment.

Questions?

There are so many different types of plans. How do I know which one is best for me or for my family?

You can make the best choice for a medical plan by considering a number of factors:

- **How much do I want to pay in premiums?**

PPO plans are the most expensive, followed by POS plans, and HMO plans are generally the least expensive. Be aware that POS and HMO plans somewhat limit your choice of providers, so you must balance your need to choose a particular provider against the premium cost of a particular plan.

- **How important is it to me to be able to choose my own provider?**

PPO plans allow the widest choice, followed by POS plans, and HMO plans limit your choice to a primary care physician who participates in the network.

- **What will my out-of-pocket costs be? Are there copayments? Do I have to pay a deductible with a certain plan?**

PPO plans have the highest copayments, while POS and HMO plans have the lowest when services are obtained in-network. If you go out-of-network in the PPO or POS plan, your services are subject to a deductible and coinsurance. See the medical benefit chart for more information.

- **What providers participate in the plan's network?**

You must call the medical plan for this information because providers don't always know the correct information. Even if your provider says that he or she participates in a particular network, you still must call the medical plan to confirm participation. Providers or the plan may choose to terminate their association.

- **What, if any, coverage is available if I choose a provider who does not participate in the network?**

HMO plans cover nothing if you go out-of-network. PPO and POS plans offer some coverage, but your cost will be higher, including deductibles and coinsurance payments. See the medical benefit chart for more information.

- **How do I obtain care from a specialist?**

PPO plans allow you to go directly to a specialist without preauthorization. POS plans, when using in-network services, require preauthorization from the plan before you see a specialist. HMO plans always require preauthorization before you see a specialist.

- **Do I need to file claim forms?**

When you use any of the plans in-network, you won't have to file claim forms. In HMO plans, you never have to file claim forms. Out-of-network care or care received from a non-participating provider will require submission of claim forms. Call your plan for more information on how to obtain claim forms.

Choosing a medical plan is a very personal choice. Please read the medical section thoroughly so that you are aware of the benefits and limitations of each type of plan. Being informed will help you choose the plan most suited to your needs and your family's needs. If you have further questions concerning coverage for particular treatments or In- or Out-of-Network coverage, please contact your plan at the phone number listed on the back cover of this book.



MEDICAL





MEDICAL

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS

Benefit	PPO In-Network Coverage	PPO Out-of- Network Coverage	POS In-Network Coverage	POS Out-of- Network Coverage	HMO Coverage (All care must be preauthorized)
Deductibles	None	\$250	None	\$250	None
Individual	None	\$500	None	\$500	None
Family					
Out of Pocket Maximums*	None	\$3,000	None	\$3,000	None
Individual		Individual		Individual	
Family		\$6,000		\$6,000	
		Family		Family	
*Any fees above the plans allowed amount are not counted toward the Out of Pocket Maximum.					
Lifetime Maximums	The Lifetime Maximum per each covered individual (i.e. employee or retiree, spouse, child(ren)) is \$2 million per lifetime.				
Physicians Primary Care Office Visit	100% after \$15 copay	80% after deductible	100% after \$5 copay	80% after deductible	100% after \$5 copay
Specialist Office Visit	100% after \$20 copay	80% after deductible	100% after \$10 copay	80% after deductible	100% after \$10 copay
Routine Annual GYN Exam	100% after \$15 copay	80% after deductible	100% after \$5 copay when preauthorized by Plan	80% after deductible	100% after \$5 copay when preauthorized by Plan
Inpatient Care Requires Preauthorization	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Outpatient Surgery May require Preauthorization	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Hospitalization	100% for 365 days	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan	80% after deductible; 100% after emergency admission	100% when preauthorized by Plan
Surgery (Subject to pre- authorization)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of- Network Coverage	POS In-Network Coverage	POS Out-of- Network Coverage	HMO Coverage (All care must be preauthorized)
Anesthesia Services	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Maternity Benefits	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Includes pre/post natal care and delivery. 2nd opinion required for non-emergency C-section)					
Newborn Care	100%	80% after deductible	100% for enrolled newborn when preauthorized by Plan	80% after deductible	100% for enrolled newborn when preauthorized by Plan
(Must be enrolled within 60 days of birth with Employee Benefits Division. See Agency Benefits Coordinator)					
Diagnostic Lab & X-ray	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Chiropractic Services	100% after \$20 copay	80% after deductible	100 % when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Acupuncture Services for Chronic Pain Management	100% after \$20 copay	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Whole Blood Charges	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Medical Supplies	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

(Includes but not limited to: surgical dressings; casts; splints; syringes; dressings for cancer, burns or diabetic ulcers; catheters; colostomy bags; oxygen; supplies for renal dialysis equipment & machines; and all diabetic supplies as mandated by Maryland law) **Contact Plan for details on covered items.**



MEDICAL



MEDICAL

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of- Network Coverage	POS In-Network Coverage	POS Out-of- Network Coverage	HMO Coverage (All care must be preauthorized)
Organ Transplants					
• Per calendar year for cornea, kidney, and bone marrow	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
• Per 365 days up to \$1 million per heart, heart-lung, single or double lung, liver, and pancreas	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Durable Medical Equipment	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Contact Plan for further details on covered items.					
Chemo-therapy/ Radiation	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan Benefit
Therapies	100% after \$20 copay Initial Evaluation & Re-evaluation	80% after deductible	100% after \$10 copay when preauthorized by Plan	80% after deductible	100% after \$10 copay when preauthorized by Plan
<ul style="list-style-type: none"> • Occupational Therapy (up to 100 visits per year when combined with Physical Therapy) • Physical Therapy (up to 100 visits per year when combined with Occupational Therapy) • Speech Therapy (up to 50 visits per year) 					
Private Duty Nursing (Must be preauthorized by all plans)	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of- Network Coverage	POS In-Network Coverage	POS Out-of- Network Coverage	HMO Coverage (All care must be preauthorized)
Second Opinion (Surgical)	100%	100%	100%	100%	100% when preauthorized by Plan, or when required by Plan
Ambulance Services	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies	100% for medical emergencies
Urgent Care Centers	\$10 copay	\$10 copay 80% after deductible	\$10 copay	\$10 copay 80% after deductible	\$10 copay
Emergency Room Services - Inside and Outside of Service Area	100% after \$25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan cover- age is 50% of allowable amount, plus \$25 copayment	100% after \$25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan cover- age is 50% of allowable amount, plus \$25 copayment	100% after \$25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan cover- age is 50% of allowable amount, plus \$25 copayment	100% after \$25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan cover- age is 50% of allowable amount, plus \$25 copayment	100% after \$25 copayment. Copayment waived if admitted. If criteria are not met for a medical emergency, plan cover- age is 50% of allowable amount, plus \$25 copayment

NOTE: Emergency Services or Medical Emergency: Health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. Placing the patient's health in jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.



MEDICAL

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of- Network Coverage	POS In-Network Coverage	POS Out-of- Network Coverage	HMO Coverage (All care must be preauthorized)
Mental Health/ Substance Abuse	NOT COVERED BY PLAN Covered by State Mental Health Plan APS	NOT COVERED BY PLAN Covered by State Mental Health Plan APS	NOT COVERED BY PLAN Covered by State Mental Health Plan APS	NOT COVERED BY PLAN Covered by State Mental Health Plan APS	100% for in- patient care up to 365 days when preauthorized by Plan. 80% for out- patient care, visits 1-5; 65% for out- patient care, visits 6-30; 50% for out- patient care, visits 30+ per calendar year.
Extended Care Facility	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(For up to 180 days per calendar year of skilled nursing care when medically necessary)					
Hospice	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
Home Health Care	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(For up to 120 days per calendar year)					
Mammo- graphy	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(Certain age restrictions and timeframes apply for screening mamograms. Call your plan.)					
Pap Test	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.



MEDICAL



This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of- Network Coverage	POS In-Network Coverage	POS Out-of- Network Coverage	HMO Coverage (All care must be preauthorized)
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Family Planning & Fertility Testing	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
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(Including: sperm count hysterosalpingography, endometrial biopsy, IUD insertion, vasectomy, tubal ligation. Only 1 reversal covered per lifetime)

In Vitro Fertilization (IVF) and Artificial Insemination NOTE: Contact your plan for further details on Preauthor- ization Require- ments:	100% for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime	80% after deductible for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime	100% when preauthorized by Plan for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime	80% after deductible for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime	100% when preauthorized by Plan for up to 3 attempts of Artificial Insemination, and 3 attempts of IVF per live birth - per lifetime
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Member must
be married.
Not covered
for surrogate
motherhood.

In-Vitro Fertilization (IVF) and Artificial Insemination (AI) benefits are available for a married (in accordance with a ceremony recognized by the laws of Maryland) woman if she was infertile:

- throughout the most recent two(2) years of marriage to the same man; or
- her infertility is due to endometriosis, exposure in womb to diethylstilbestrol (DES), or blockage of or surgical removal of one or more fallopian tubes; or
- male infertility is the documented diagnostic cause.

The patient's oocytes must be fertilized with the patient's spouse's sperm. In-Vitro Fertilization and Artificial Insemination are covered for a maximum of 3 attempts per procedure.

THIS IS ONLY A SUMMARY. CONTACT YOUR PLAN FOR FURTHER DETAILS ON PREAUTHORIZATION REQUIREMENTS.

- The 3 IVF attempts per live birth will not exceed a maximum expense of \$100,000 per lifetime.
- The Artificial Insemination attempts must be taken, when medically appropriate, before IVF attempts will be covered.

Norplant Surgery Only	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
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MEDICAL



MEDICAL

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of- Network Coverage	POS In-Network Coverage	POS Out-of- Network Coverage	HMO Coverage (All care must be preauthorized)
Well-Baby Care Under 1 year: 6 visits; 1-2 years: 2 visits; 2 years +: 1 visit per yr	100% after \$15 copay per visit, to age 12	80% after deductible per visit, to age 12	100% after \$5 copay per visit, to age 12, when preauthorized by Plan	NOT COVERED	100% after \$5 copay per visit, to age 12, when preauthorized by Plan
Immunizations	100%	80% after deductible	100% when preauthorized by Plan	80% after deductible	100% when preauthorized by Plan
(As recommended by the American Medical Association and the American Academy of Pediatrics, including immunizations required for participation in school athletics; including Lyme Disease.) (Contact your plan for further details)					
Physical Exams - 1 every 3 years for all members and their depen- dents age 13 and older	100% after \$15 copay	80% after deductible	100% after \$5 copay if preautho- rized by Plan	NOT COVERED	100% after \$5 copay for exam when preauthorized by Plan
Hearing Examinations and Hearing Aids, including mandated benefit for hearing aids for minor children (ages 0-18) as mandated by Maryland law effective January 1, 2002, including hearing aids per each impaired ear for minor children.	100% after \$15 copay for exam. 100% for Basic Model hearing aid. 1 exam and hearing aid every 3 years for each employee and dependent.	80% after deductible	100% after \$5 copay for exam when preauthorized by Plan. 100% for Basic Model hear- ing aid. 1 exam and hearing aid every 3 years for each employee and dependent.	NOT COVERED, except for hearing aids as mandated for minor children (ages 0-18) as mandated by Maryland law effective January 1, 2002.	100% after \$5 copay for exam when preauthorized by Plan. 100% for Basic Model hear- ing aid. 1 exam and hearing aid every 3 years for each employee and dependent.

NOTE: The percentages referred to in the above chart are percentages that the plan will pay based upon the plan's maximum allowed amount. A non-participating or Out-of-Network provider may charge more than the plan's allowed amount. You are responsible for any fees above the plan's allowed amount.

This chart is a summary of generally available benefits, and does not guarantee coverage. To ensure coverage under any plan, contact that plan before obtaining any services or treatment. Call the plan for more information on coverage, limitations, exclusions, determinations of medical necessity, and preauthorization requirements. In addition, you will receive a Summary Plan Description (SPD) from the plan in which you enroll that will provide details on your plan coverage.

STANDARD BENEFITS CHART FOR MEDICAL PLANS (Cont'd)

Benefit	PPO In-Network Coverage	PPO Out-of- Network Coverage	POS In-Network Coverage	POS Out-of- Network Coverage	HMO Coverage (All care must be preauthorized)
Allergy Testing	100% after \$15 copay	80% after deductible	100% after \$5 copay when preauthorized by Plan	80% after deductible	100% after \$5 copay when preauthorized by Plan
Diabetic Nutritional Counseling as mandated by Maryland law	100% after \$15 copay	80% after deductible	100% after \$5 copay when preauthorized by Plan	80% after deductible	100% after \$5 copay when preauthorized by Plan
Prescription Drugs	NOT COVERED UNDER MEDICAL PLAN				
Dental Services	NOT COVERED UNDER MEDICAL PLAN				
<u>Vision - MEDICAL</u>					
Any services that deal with the medical health of the eye	100% after \$15 copay (primary care physician) or \$20 copay (specialist)	80% after deductible	100% after \$5 copay or \$10 copay (spe- cialist) when preauthorized by Plan	80% after deductible	100% after \$5 copay or \$10 copay (spe- cialist) when preauthorized by Plan

Vision - ROUTINE

(Provided by
your health
plan) – Any
services that
deal with
correcting
vision.

Plan Pays Up To: Exam - \$45 (Available once every year)

Prescription Lenses (per pair) - (Available once every year)

- Single Vision - \$ 28.80
- Bifocal, single - \$ 48.60
- Bifocal, Double - \$ 88.20
- Trifocal - \$ 70.20
- Aphakic: Glass - \$ 54.00
- Plastic - \$126.00
- Aspheric - \$162.00

Frames - \$45 (Available once every year)

Contacts (per pair, **in lieu of frames and lenses**). Available once every year.

- Medically Necessary - \$201.60
- Cosmetic - \$50.40

Vision benefits are only available through your health plan. You may obtain vision services from any licensed vision provider, whether in your health plan or not. To obtain vision benefits, you must contact your medical plan for more information. Vision benefits are available once every year.



MEDICAL



MEDICAL

General Limitations and Exclusions

This is a general summary of limitations and exclusions. This list is subject to change at any time. Please call the plan for further information.

The State does not cover services and supplies:

- for services not deemed medically necessary by the Plan,
- not prescribed, done, or guided by eligible practitioners,
- when you are not legally obligated to pay for the charge, or where the charge is made only to insured persons,
- provided through a dental or medical department of an employer, a mutual benefit association, a labor union, a trust, or a similar entity,
- for personal hygiene, cosmetic and convenience items, air conditioners, humidifiers, exercise equipment, elevators or ramps, even if recommended or prescribed by a physician,
- for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services,
- for separate billings for services or supplies furnished by an employee or a hospital or practitioner which are normally included in such hospital's or practitioner's charges and billed for by them,
- provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner,
- for treatment of a patient who is discharged from a hospital, facility, or institution and readmitted within 14 days after their effective date when such discharge and readmission was for the purpose of qualifying for coverage under this benefit plan,
- for court-ordered examinations, care, or confinement, unless otherwise medically necessary,
- rendered or available under any Workers Compensation or occupational disease, or employer's liability law, or any other similar law, even if the member fails to claim benefits,
- that are excluded from coverage under Medicare,
- to the extent the services and supplies are provided under Medicare,
- for the treatment of any injury, illness, or medical condition that is not medically necessary,
- for illnesses resulting from an act of war,
- for any illness due to a criminal act if the member is the principal or aids in its commission,
- for cosmetic surgery, or cosmetic surgery performed to treat a psychiatric or emotional condition except as may otherwise be specifically provided in this benefit plan,
- for sex changes,
- primarily for custodial care or rest cures,
- that are provided for care of any kind in connection with habilitation,
- cardiac rehabilitation when not done because of single-lung, double-lung, heart, or heart-lung transplant,
- for conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for hospital stays for environmental change,
- for milieu care or In-Vivo therapy,
- for non-medical or non-surgical self-care or self-help training,
- for treatment of obesity (except morbid obesity), weight reduction, or dietary control,
- for routine podiatry care unrelated to diabetes mellitus and peripheral vascular disease and diabetic neuropathy,
- for inpatient private duty nursing services,
- diagnostic services for:
 - the interpretation of clinical lab tests, such as blood counts, when practitioner's service is only administrative
 - fluoroscopy without films
 - care of teeth
 - tests not ordered by a practitioner
 - research tests
 - screening tests when there are no symptoms or patient complaint except for routine examinations except as mandated by law
 - pre-marital exams
- a transplant or procurement done outside the continental U.S.
- covered services if there are research funds to pay for the covered services,
- services or supplies to the recipient or companion(s) if no payment is required,
- expenses incurred for the location of a suitable donor, e.g. the National Bone Registry.

Special Information on HMOs:

Some State employees may be interested in knowing an HMO's corporate status before choosing a medical plan. The following is a chart illustrating for-profit and not-for-profit HMOs in the 2003 State of Maryland benefits program, along with their payment methods for primary care physicians (PCP) and specialists. This chart is provided for your information only, and is not a recommendation for any specific type of HMO. Please call your plan for more information.

HMO	Corporate Status	Payment Method(s) for Physicians
Blue Choice	For-Profit	Discounted Fee-for-Service
Kaiser Permanente	Not-for-Profit	Salaried Employees
Optimum Choice (MAMSI)	For-Profit	PCPs: Capitation based upon age and sex of PCP's patients Specialists: Negotiated Fee Maximums

**Health Services Cost Review Commission.

HMO Report Cards: The Maryland Health Care Commission (MHCC) develops an annual "HMO Report Card." This publication entitled "Comparing the Quality of Maryland HMO's, A Guide for Consumers," is available free at all public libraries, and on the Internet at www.mhcc.state.md.us. During Open Enrollment, MHCC also creates a special edition of the HMO guide specifically for employees of the State of Maryland. You should have received a copy of that booklet, called "Comparing the Quality of Maryland HMO's, A Guide for State Employees," with this booklet and other materials describing the employee benefits for 2003. Please see your Agency Benefits Coordinator to request a copy of the HMO guide.



MEDICAL





PRESCRIPTION



PRESCRIPTION PLAN

General Description of Coverage

Prescription plan coverage is available to all individuals and their dependents who are eligible for health benefits with the State. The State's prescription plan is administered by AdvancePCS, Inc. The prescription plan covers the cost of most approved prescription drugs, subject to nominal copayments. These copayments are determined by whether the drug is on the AdvancePCS formulary and whether the drug is a brand-name or generic.

Certain drugs are not covered under this plan.

Formulary: A formulary is a selected list of drugs. AdvancePCS has a panel of physicians and pharmacists that meets regularly to identify and review prescription drugs that provide the highest therapeutic and economic value. By choosing drugs on this list, your physician helps keep the cost of prescription drugs affordable. Formulary drugs are subject to change at any time. Your physician may contact AdvancePCS to obtain information on formulary drugs.

Brand-name drug: A brand-name drug is any approved drug a particular pharmaceutical company has the exclusive right to produce and sell. Over time, companies can lose the patents on particular drugs, opening up the market to generic equivalents. Generic drug equivalents may become available at any time.

Generic drug: A generic drug is made with the same active ingredient as found in the brand-name product. All generics must meet the same manufacturing and testing standards as the brand-name drug. If a generic drug is available, the State plan only covers up to the cost of the generic.

NOTE: The State prescription plan only covers up to the cost of a generic drug, when the generic is available. If you purchase a brand-name drug when a generic drug is available, even if it is prescribed by your physician, you must pay the difference in price between the brand-name and the generic, as well as the standard copayment amount. The plan does not pass judgment on a physician's determination as to the appropriate medication for treatment, but the plan does have limitations as to the types and amounts of reimbursement available.

How to Receive Prescription Plan Benefits

Please take your AdvancePCS card with you when you get your prescriptions filled. If you are enrolling in the prescription plan for the first time, AdvancePCS will issue you a maximum of two cards per family. An additional card may be ordered for students residing out of state, by calling AdvancePCS. Any stolen cards must be reported to AdvancePCS immediately. All cards are issued with the name of the employee or retiree embossed on the card. Dependent names are not listed on the card.

If you choose a formulary drug, you will pay a \$5 copayment when you purchase the drug. If your physician has prescribed a drug that is not on the AdvancePCS formulary, the copayment will be \$10. If you purchase a brand-name drug when a generic drug is available, you must pay the difference between the brand-name and generic drug, in addition to the standard copayment amount of \$5 or \$10. AdvancePCS is also offering State members a list of preferred Performance drugs (see the following section), which have \$3.00 copayments.

Preferred Performance drugs, Formulary drugs, and Non-formulary drugs are subject to change at anytime.



PRESCRIPTION

Participating Pharmacies: If you use a pharmacy that participates in the AdvancePCS network, you only need to pay the necessary copayment at the time of service. More than 900 pharmacies in the State of Maryland participate in the AdvancePCS network. AdvancePCS also has a nationwide network of participating pharmacies. If you are traveling out-of-state or just want to know if a particular pharmacy participates in the AdvancePCS network, contact AdvancePCS at the phone number listed on the back cover of this book. If you visit a pharmacy that is not a member of the AdvancePCS network, you must pay the pharmacist the entire cost of your prescription drug and submit a paper claim form to AdvancePCS for reimbursement. You will be reimbursed the amount that the State would have paid to an AdvancePCS pharmacy minus a \$12.50 copayment. This amount may be less than your out-of-pocket cost. **You have one year from the date you have a prescription filled to submit a paper claim to AdvancePCS.**

If you must obtain a prescription without an AdvancePCS Enrollment Card, you will need to submit an AdvancePCS claim form for reimbursement. Please send your completed claim form and receipt to: Employee Benefits Division, 301 W. Preston St., Room 510, Baltimore, MD 21201 Attn: AdvancePCS Coordinator. All claims must be submitted within one year of the date of service.

Preferred Performance Drugs: Certain drugs, which are called "Preferred Performance drugs," are available for a \$3 copayment. Please review this listing of Preferred Performance drugs with your physician. **Preferred Performance Drugs are subject to change at anytime.** Contact AdvancePCS at the number listed on the back cover for the most current information on "Preferred Performance Drugs."

Maintenance Drugs: Some prescription drugs may be available in 90- or in 100-day supplies, depending on State law or AdvancePCS policy. Please contact AdvancePCS for more information on drugs that may be prescribed in 100-day supplies. Please see your physician for more information on drugs that may be prescribed in 90-day supplies under State law.

Questions

How much will I have to pay?

1. If you receive a formulary drug, you pay \$5.
2. If you receive a non-formulary drug even though a formulary drug is available, you pay \$10.
3. If you purchase a brand-name drug when a generic is available, you must pay the difference between the brand-name and generic drug, and the standard copayment amount of \$5 or \$10.
4. If you purchase a preferred performance drug, your copayment is \$3.

What happens when I use a non-participating pharmacy?

You pay the total cost to your pharmacy and submit a paper claim to AdvancePCS. You are reimbursed for the balance after your portion of the cost is determined. Your portion of the total cost is a \$12.50 copayment plus the difference between the total charges and what the State would pay a participating pharmacy. If you purchase a brand-name drug when a generic is available, you are also responsible for the difference in cost between the brand-name and generic drug. Contact AdvancePCS for claim forms. All claims must be submitted within one year of the date of purchase. Any claims more than one year old will not be reimbursed.

My pharmacist just told me it is too soon to refill my prescription. Why?

All of your drug plan prescriptions are screened by the AdvancePCS computerized concurrent drug utilization review monitoring system called QUANTUM Alert. The QUANTUM Alert program automatically calculates how long it would take you to use up to 75% of your prescription. If you attempt to refill your prescription before the calculated date, your refill will not be honored by AdvancePCS.



PRESCRIPTION



NOTE: There are some circumstances when you will be allowed to obtain an early refill or advance supply of a drug, such as when you are going on vacation, for a dosage change during the course of treatment, or for lost or destroyed medication. You or your physician must contact AdvancePCS to obtain prior authorization for an early refill or advance supply of a prescription. Your pharmacist can also call the AdvancePCS Help Desk to assist you in obtaining an early refill or advance supply. See phone numbers on the back cover of this book.

When is prior authorization needed?

Certain drugs require prior authorization (called Managed Access) and are subject to certain constraints before coverage will be provided. Drugs requiring prior authorization include: Retin- A for individuals age 26 and older, growth hormones, dexedrine, Adderall, and phenylbutazone. You must contact AdvancePCS to obtain prior authorization on these drugs. **The list of drugs requiring prior authorization is subject to change at any time.** See phone numbers on the back cover of this book.

Other Questions?

If you have any questions about coverage, exclusions, or limitations, or need to report stolen or missing cards, please contact AdvancePCS at the phone number listed on the back cover of this book.

The chart on page 24 gives examples of the types of drugs that are covered and those that are excluded. This is not a comprehensive list and is subject to change at any time. If you have any questions about a particular drug, please contact AdvancePCS at the phone number listed on the back cover.

Preferred Performance Drugs – Subject to change at any time

Cardiovascular

Ace Inhibitors

- Captopril
- Enalapril
- Accupril®/Accuretic™
- Altace
- Lisinopril

Angiotensin II Receptor Blockers

- Avapro®/Avalide®
- Cozaar®/Hyzaar®

Beta Blockers

- Atenolol
- Toprol-XL
- Metoprolol
- Propranolol

Calcium Channel Blockers

- Diltiazem Ext-rel¹
- Verapamil Ext-rel²
- Nifedipine Ext-Rel⁶
- Norvasc®

HMG Co-A Reductase Inhibitors

- Lipitor®
- Pravachol®

Depression

SSRIs

- Celexa™
- Fluoxetine
- Paxil®/Paxil CR™
- Zoloft

Other Antidepressants

- Bupropion
- Effexor®/Effexor XR®
- Remeron®/Remeron SolTabs®
- Wellbutrin SR®

Diabetes

Biguanides/Combination Product

- Metformin
- Glucovance®

Sulfonylureas

- Glipizide
- Glyburide/Glyburide micronized
- Amaryl®
- Glucotrol XL®

Thiazolidinediones

- Actos®
- Avandia®

Insulin Product Lines

- Humalog®/Humulin®
- Lantus®
- Novolin®/Novolog®

Gastrointestinal Agents

H2-Antagonists

- Cimetidine
- Ranitidine tabs

Proton Pump Inhibitors

- Aciphex™
- Nexium™
- Prilosec®

Infection Agents

Antimicrobials

Cephalosporins

- Ceflacor
- Cephalexin
- Cedax®
- Omnicef®

Macrolides

- Erythromycins³
- Blaxin®/Biaxin® XL
- Zithromax®



PRESCRIPTION



Preferred Performance Drugs (continued) – Subject to change at any time

Penicillins

- Amoxicillin
- Dicloxacillin
- Penicillin VK
- Augmentin®

Fluoroquinolones

- Avelox®
- Cipro®
- Levaquin

Tetracyclines

- Doxycycline hyclate
- Minocycline
- Tetracycline

Miscellaneous

- Metronidazole
- Sulfamethoxazole/trimethoprim

Antifungals

Onychomycosis

- Lamisil®

Antivirals

Herpes

- Acyclovir
- Valtrex®

Low Molecular Weight Heparins

- Lovenox®

Migraine

Triptans

- Imitrex®
- Maxalt®/Maxalt-MLT™
- Zomig®/Zomig-ZMT™

Ophthalmic

Antimicrobials

- Polymycin B/Trimethoprim
- Tobramycin
- Ocuflox®

Glaucoma

Beta Blockers

- Timolol Maleate solution
- Betimol®

Alpha Agonists

- Alphagan®/Alphagan P®

Prostaglandins/Prostamides

- Lumigan™
- Xalatan®

Osteoarthritis

NSAIDs

- Ibuprofen
- Indomethacin
- Naproxen
- Naproxen Sodium
- Sulindac

COX-2 Inhibitors

- Celebrex®
- Vioxx®

Pain

Analgesics - Moderate to Severe

Pain

- Morphine ext-rel
- OxyContin®

Respiratory

Allergy

Antihistamines - Nasal

- Astelin®

Antihistamines - Nonsedating

- Allegra®/Allegra-D®
- Clarinex®
- Claritin®/Claritin-D®

Corticosteroids - Nasal

- Flonase®
- Nasacort®/Nasacort®AQ
- Nasonex®
- Rhinocort®/Rhinocort®

Aqua™

Asthma

Beta Agonist Inhalers

- Albuterol
- Serevent®/Severent Diskus®

Corticosteroid Inhalers

- Flovent®/Flovent®

Rotadisk®

- Azmacort®
- Pulmicort Turbuhaler

Corticosteroid/Beta Agonist

Combinations

- Advair™ Diskus®

Leukotriene Modifiers

- Accolate®
- Singulair

Thyroid Replacement

- Levothy®
- Synthroid®

Urologic Disorders

Benign Prostatic Hypertrophy

- Doxazosin
- Terazosin

Urinary Incontinence

- Oxybutynin
- Detrol®/Detrol® LA

Women's Health

Osteoporosis

Hormone Replacement - Oral

- Estradiol
- Estropipate
- Cenestin®
- Femhrt™
- Premarin®
- Premphase®
- Prempro™

Hormone Replacement -

Transdermal Estradiol⁴

- Esclim™
- Estraderm®
- Estradiol^{6,7}
- Vivelle®/Vivelle-Dot™

Selective Estrogen Receptor

Modulators

- Evista®

Bisphosphonates

- Fosomax®

Oral Contraceptives

Monophasic

- Lo-Ovral®
- Levora®
- Loestrin/Loestrin Fe
- Low-Orgestrel
- Mircette®
- Modicon®
- Ortho-Cept®
- Ortho-Cyclen®
- Ortho-Evra-transdermal™
- Ortho-Novum⁵
- Zovia®
- Yasmin®

Triphasic

- Estrostep® Fe
- Ortho-Novum® 7/7/7
- Ortho-Tri-Cylen®
- Tri-Norinyl®
- Trivora®
- Cyclessa™

Progestin-only

- Ortho Micronor®

Miscellaneous

- Nuva Ring®

¹ Generic equivalents of Cardizem® CD or Dilacor XR®

² Generic equivalent of Calan® SR and Isonit® SR

³ Generic equivalent of E.E.S.®, E-Mycin®, ERYC®, Erythrocin®, and Pediazole®

⁴ Generic equivalents of Climara®

⁵ Includes Ortho-Novum® 1/35, 1/50 and 10/11

⁶ Generic equivalents of Adalat® CC or Procardia XL®

⁷ Generic equivalents of Climara®



PRESCRIPTION



Standard Prescription Plan Benefits Chart

Subject to change at any time

Covered Drugs

Insulin, rabies vaccine, ceredase, and most legend drugs prescribed on an outpatient basis, including:
 Allergy Serum;
 Compounded medication of which at least one ingredient is a legend drug;
 Lupron;
 Oral contraceptives, Norplant, Depo-Provera;
 Ritalin;
 Tretinoin, all dosage forms (e.g., Retin-A) for individuals through the age of 25; Rocaltrol; and Pre-Natal Vitamins.

NOTE: Allergy Serum is covered through the AdvancePCS Prescription Drug Plan. Claims for reimbursement of Allergy Serum should be submitted to AdvancePCS. Claims for reimbursement of allergy testing and physician services associated with allergy injections should be submitted to your health plan.

NOTE: The Prescription Drug Plan does not coordinate benefits with any other plan.

NOTE: AdvancePCS will reimburse a claim for Meningitis Vaccines provided according to the Maryland law, for students attending a university in Maryland.. Please submit your AdvancePCS claim and receipt to the AdvancePCS Coordinator at the Employee Benefits Division. Any associated physician bills should be submitted to your health plan.

Excluded Drugs

Anorectics (any drug used for the purpose of weight loss);
 Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order;
 Charges for administration or injection of any drug;
 Contraceptive devices;
 DESI drugs (drugs determined by the Food and Drug Administration as lacking substantial evidence of effectiveness);
 Dietary supplements;
 Drugs labeled "Caution-limited by federal law to investigational use or experimental drugs," even though a charge is made to the individual;
 Immunization agents, biological sera, blood, or blood plasma;
 Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent home, nursing home, veterans hospital or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
 Minoxidil (Rogaine);
 Non-legend drugs other than insulin and rabies vaccines and ceredase;
 Prescriptions that an eligible person is entitled to receive without charge under Workers' Compensation Law;
 Therapeutic devices or appliances, including needles, syringes, support garments, and other non-medical substances, regardless of intended use; or,
 Vitamins, singly or in combination, including fluoride (exception: Rocaltrol and Pre-Natal Vitamins);
 Anti-wrinkle agents (e.g., Renova, Retin-A for individuals 26 years of age or older);
 Dexedrine; except through Prior Authorization;
 Growth hormones, except through Prior Authorization.



DENTAL

DENTAL PLAN

General Description of Coverage

Dental coverage is available to all individuals who are eligible for health benefits with the State.

You must be enrolled in one of the three dental plans offered if you want to have dental benefits: Dental Benefit Providers DHMO, United Concordia DHMO, or United Concordia DPOS.

If you are not enrolled in one of the three available dental plans for Year 2002, you will not have dental benefits in Year 2003.

Dental benefits are not included in any of the medical plans in Year 2003.

NOTE: You have one year from the date you receive a dental service to file a claim.

NOTE: Contact your dental plan to authorize a change to your PCP dentist. After confirmed, your new cards will be sent to your home address.

NOTE: The State cannot guarantee the continued participation of a particular provider in any of the benefit plans. Providers on the plan have the ability to terminate their association with the plan. If your plan dentist chooses to discontinue participation in the plan, is terminated from the plan, or chooses to close their panel of new patients, you will not be allowed to change your plan or withdraw from the plan until Open Enrollment. You must contact your dental plan to select another provider.

How to Receive Dental Plan Benefits

You must select a Primary Dental Office (PDO) from your selected dental plan's network of participating dentists when you enroll. You may obtain a Primary Dental Office Selection Form from your Agency Benefits Coordinator or by calling the dental plan. You are free to change your primary provider site selection at any time. Remember to verify provider participation before seeking care by calling your dental plan. Also, before you receive any services, be sure to consult the Schedule of Benefits for the type of dental plan you have chosen to ensure that you have anticipated all out-of-pocket costs and liabilities associated with a particular type of treatment.

If you reside in an area that does not have a plan network of dentists, please contact the dental plan to determine other options. You may request that the plan evaluate the dentist of your choice for inclusion in the network. If you reside outside of Maryland, call the plan to see if there is a network of providers in your area. If not, the POS plan does provide out-of-network benefits.



DENTAL

Dental Health Maintenance Organization (DHMO)

Dental Point-of-Service Plan (POS)

How the DHMO Plans Work

There are two Dental HMOs available:

- Dental Benefit Providers (DBP)
- United Concordia (UCC)

The United Concordia DHMO plan offers each family member the option of selecting a different **Primary Dental Office** from the dental network, which will provide, or arrange for, all of their dental care. The Dental Benefits Providers DHMO permits 2 dentists per family. Preventive and diagnostic dental care is covered in full, while restorative and other major services are offered at a reduced cost. Orthodontic services are available for both adults and children (call the dental plans for details and limitations). There are no claim forms and you are only responsible for copayment amounts which are part of the program design. There are no deductibles and no yearly benefit maximums. A referral is required in order to see a specialist.

You must select a primary dental office regardless of intention to use.

How the POS Program Works

The Dental POS plan is available through United Concordia. This plan offers each family member the option of receiving care at a pre-selected dental network site (the **Primary Dental Office**) or from another dental provider of their choice. If you choose to receive care outside of the Primary Dental Office, benefits are paid at a separate schedule of benefits. All preventive and diagnostic care received from the Primary Dental Office is covered in full while restorative and other major services are offered at a reduced cost. Orthodontic services are available (in-network only) for both adults and children (call United Concordia for details and limitations). There are no claim forms when you receive care in-network and you are only responsible for copayment amounts which are part of the program design. While there is no maximum benefit for in-network services, there is a maximum benefit of \$1,000 per member per calendar year out-of-network.

You must select a primary dental office regardless of intention to use.

Copayments

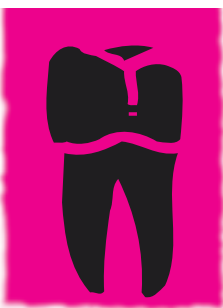
All **preventive and routine diagnostic** services are covered at 100% when services are received from the primary dental office. Review the Schedule of Benefits for each plan for the copayment amounts associated with each type of dental service. Services not listed on Schedule of Benefits are excluded from coverage.

Predetermination of Benefits

There is no general requirement for you or your primary dentist to seek predetermination of benefits before treatment starts. However, you are encouraged to do so for major dental procedures so that you and your dentist will know exactly what will be covered and what your financial liability will be.

Out-of-Area Emergencies

Your selected dental plans will pay up to a maximum of \$50, subject to your copayment, for emergency dental services when you are travelling out of the area (more than 50 miles from your dentist's office). In order to receive payment for out-of-area emergency care, you must submit a receipted bill itemizing the charges and services performed. This claim should then be forwarded to your dental plan for processing.



DENTAL



Advantages of the DHMO

When care is received **in-network**, the benefits are:

- No claim forms
- No deductibles
- No charge for Preventive and Diagnostic Services
- No pre-existing condition exclusion, except for orthodontics in progress (see Special Note on Treatment in Progress)
- Braces are covered for children and adults

THINGS TO REMEMBER

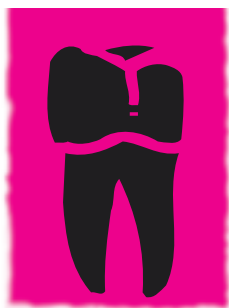
- You can enroll in any of the three available dental plans
- You, or a family member, can change your primary dentist at any time (if no balance exists)
- Copayments are the same, regardless of whether care is rendered by a participating general dentist or a specialist

DHMO only

- Claim submission is necessary for out-of-area emergency care.
- You must obtain a referral from your primary care dental site to see a specialist.
- You must receive services from a participating plan dentist.
- You must contact the plan to designate your Primary Care Physician. Verify same PCP upon receipt of membership card.

POS only

- Out-of-pocket expenses are higher when services are received out-of-network
- Claim submission is necessary for out-of-network reimbursement and out-of area emergency care
- The out-of-network maximum benefit is \$1,000 per member per calendar year
- There are no out-of-network orthodontic benefits
- You must contact the plan to designate your Primary Care Physician. Verify same PCP upon receipt of membership card.



DENTAL



Questions?

Will every family member get a card?

Every member in any of the dental plans will receive a membership card identifying the dental plan and the name and phone number of the primary dental site.

Do I have to have my dental card with me to receive benefits?

If you are a new employee and need services, you should take your dental card with you to the initial visit. You do not have to have your dental card with you in order to receive care. Dental plan providers receive monthly lists of members registered to their site from the dental plan. Providers in the network also can verify your plan eligibility by calling the dental plan.

Why does my membership card show an In-Network dentist? I do not use an In-Network provider.

All members must choose a primary dental office from the network of the dental plan in which you enroll. However under the United Concordia POS Plan, you have the option of receiving most care from a provider other than your primary dentist. When a decision is made to receive care outside of your primary dental office, benefits are paid in accordance with a separate schedule of benefits, except for excluded services. Additionally you are subject to balance billing for the difference between the plan payment and the provider's charge.

Must family members go to the same dentist?

No. For the United Concordia Dental Plans offered, each family member may select a different participating general dental office. For the Dental Benefits Provider DHMO, up to 2 dentists may be selected per family.

Can I change dentists? How do I change dentists?

All employees of the State of Maryland and their dependents can change dentists at any time, as long as there is no balance at the existing provider site. To change dentists, you simply call your dental plan. A representative can assist you with your new selection and can tell you when your selection is effective and expect new cards.

Do I have to fill out claim forms after each routine visit?

Under the United Concordia POS Plan, you must submit claim forms if you are seeking reimbursement for eligible out-of-network services. Under the two DHMO plans, you must submit a claim for out-of-area-emergency care.

Is there an extra charge for care provided by a specialist?

The fee schedule remains the same whether your care was provided by a general dentist or a specialist, except for excluded services. THERE ARE NO OTHER PRE-EXISTING CONDITION LIMITATIONS.

Do I have to be referred to a specialist?

You must be referred to a participating specialist by your participating general dentist in order to be eligible for in-network specialist benefits.

What about orthodontia for adults and children?

Orthodontic benefits are available to all enrolled members, children and adults alike. Orthodontic benefits must be received from an In-Network provider in all three of the dental plans offered. There is no Out-of-Network coverage for orthodontic treatment.

NOTE: Dentists may choose to provide services that are excluded from your State of Maryland benefits. The plan does not pass judgement on a dentist's determination as to the appropriate dental treatment, but the plan will not cover excluded services.



Other Questions?

For more information, call **Dental Benefit Providers** or **United Concordia** at the phone number listed on the back cover of this book.

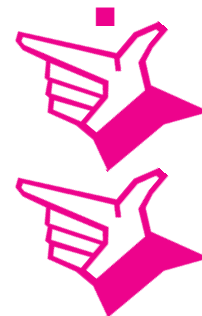
SPECIAL NOTE ON TREATMENT IN PROGRESS AND ORTHODONTIA: If you switch dental plans as a result of your dental selection for Year 2002, the current dentist is required to complete Treatment in Progress as defined by Maryland law (other than orthodontia) as of December 31, 2002.

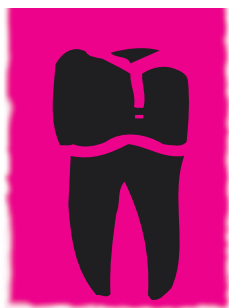
If you or a family member has treatment in progress or orthodontia treatment in progress as of December 31, 2002 and you switch dental plans, you must contact the new dental plan prior to January 1, 2003 to discuss possible orthodontia treatment arrangements.

****New employees, who have orthodontic treatment in progress, must contact the dental plan. Orthodontic care may be denied as pre-existing treatment. The dental plan will require the member to pay the orthodontic copayments, even if the member has previously paid copayments to the previous orthodontist.**



DENTAL





DENTAL

Dental Benefits Providers (DBP) DHMO Schedule of Fees

ADA CODE	PROCEDURE NAME	MEMBER PAYS	ADA CODE	PROCEDURE NAME	MEMBER PAYS
DIAGNOSTIC (EXAMS AND X-RAYS)			MAJOR RESTORATIVE (CROWNS) Continued		
120	PERIODIC ORAL EXAMINATION (EVERY 6 MONTHS)	0	2790	CROWN-FULL CAST HIGH NOBLE METAL	215
140	LTD ORAL EVALUATION - PROBLEM FOCUSED	0	2791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	195
150	COMPREHENSIVE ORAL EVALUATION	0	2792	CROWN-FULL CAST NOBLE METAL	205
210	INTRAORAL-COMPLETE SERIES INCLUDING BITEWINGS	0	2810	CROWN-3/4 CAST METALLIC	215
220	INTRAORAL-PERAPICAL-FIRST FILM	0	2910	RECEMENT INLAY	16
230	INTRAORAL-PERAPICAL-EACH ADDITIONAL FILM	0	2920	RECEMENT CROWN	15
240	INTRAORAL-OCCLUSAL FILM	0	2930	PREFABRICATED STAINLESS STEEL CROWN-PRIMARY TOOTH	50
270	BITEWING-SINGLE FILM	0	2931	PREFABRICATED STAINLESS STEEL CROWN-PERMANENT TOOTH	50
272	BITEWINGS - TWO FILMS	0	2932	PREFABRICATED RESIN CROWN	45
273	BITEWINGS - THREE FILMS	0	2940	SEDATIVE FILLINGS	16
274	BITEWINGS - FOUR FILMS	0	2950	CROWN BUILDUP (SUBSTRUCTURE) WITH PINS	50
330	PANORAMIC FILM	0	2951	PIN RETENTION-PER TOOTH IN ADDITION TO RESTORATION	9
460	PULP VITALITY TESTS	0	2952	CAST POST & CORE IN ADDITION TO CROWN	65
470	DIAGNOSTIC CASTS	0	2954	PREFAB POST & CORE IN ADDITION TO CROWN	55
			2970	TEMPORARY CROWN (FRACTURED TOOTH)	45
			2980	CROWN REPAIR	40
PREVENTIVE (CLEANINGS & FLUORIDE)			ENDODONTICS (ROOT CANALS)		
1110	PROPHYLAXIS ADULT (EVERY 6 MONTHS)	0	3110	PULP CAP-DIRECT EXCLUDING FINAL RESTORATION	4
1120	PROPHYLAXIS-CHILD (EVERY 6 MONTHS)	0	3120	PULP CAP-INDIRECT EXCLUDING FINAL RESTORATION	3
1201	TOP APPL FLUOR INCL PROPHY-CHILD - AGE 16 (EVERY 6 MONTHS)	0	3220	THERAPEUTIC PULPOTOMY EXCLUDING FINAL RESTORATION	10
1203	TOP APPL FLUOR EXCL PROPHY-CHILD - AGE 16 (EVERY 6 MONTHS)	0	3310	ROOT CANAL THERAPY - ANTERIOR EXCLUDING FINAL RESTORATION	45
1205	TOP APPL FLUOR INCL PROPHY-ADULT - AGE 16 AND OVER (EVERY 6 MONTHS)	0	3320	ROOT CANAL THERAPY- BICUSPID EXCLUDING FINAL RESTORATION	60
1351	SEALANT - PER TOOTH (CHILD - AGE 16, LTD TO 4 PERM MOLARS (EVERY 5 YEARS)	0	3330	ROOT CANAL THERAPY- MOLAR EXCLUDING FINAL RESTORATION	85
1510	SPACE MAINTAINER-FIXED UNILATERAL	0	3346	RETREATMENT-PREV ROOT CANAL THERAP-AN	65
1515	SPACE MAINTAINER-FIXED BILATERAL	0	3347	RETREATMENT-PREVROOT CANAL THERAP-BI	80
1520	SPACE MAINTAINER-REMOVABLE UNILATERAL	0	3348	RETREATMENT-PREVROOT CANAL THERAP-MO	90
1525	SPACE MAINTAINER-REMOVABLE BILATERAL	0	3350	APEXIFICATION/RECALCIFICATION PER TREATMENT VISIT	20
1550	RECEMENTATION OF SPACE MAINTAINER	0	3410	APICOECTOMY/PERIRADICULAR SURGERY-ANTERIOR	55
			3421	APICOECTOMY/PERIRADICULAR SURGERY-BICUSPID FIRST ROOT	60
			3425	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR FIRST ROOT	70
			3426	APICOECTOMY/PERIRADICULAR SURGERY-MOLAR EACH ADDL ROOT	20
			3430	RETROGRADE FILLING-PER ROOT	20
			3450	ROOT AMPUTATION-PER ROOT	35
			3920	HEMISECTION WITH ROOT REMOVAL-WITHOUT ROOT CANAL THERAPY	35
MINOR RESTORATIVE (FILLINGS)			PERIODONTICS (GUM DISEASE)		
2110	AMALGAM-ONE SURFACE PRIMARY	0	4210	GINGIVECTOMY/GINGIVOPLASTY-PER QUADRANT	45
2120	AMALGAM-TWO SURFACES PRIMARY	0	4211	GINGIVECTOMY/GINGIVOPLASTY-PER TOOTH	15
2130	AMALGAM-THREE SURFACES PRIMARY	0	4220	GINGIVAL CURETTAGE, SURGICAL-PER QUADRANT/-BY REPORT	20
2131	AMALGAM-4 OR MORE SURFACES, PRIMARY	0	4240	GINGIVAL FLAP PROCEDURE, INCL ROOT PLANING-PER QUADRANT	55
2140	AMALGAM-ONE SURFACE PERMANENT	0	4249	CROWN LENGTHENING-HARD/SOFT TISSUE BY REPORT	65
2150	AMALGAM-TWO SURFACES PERMANENT	0	4250	MUCO-GINGIVAL SURGERY-PER QUADRANT	60
2160	AMALGAM-THREE SURFACES PERMANENT	0	4260	OSSEOUS SURGERY, INCLUDING FLAP ENTRY & CLOSURE	90
2161	AMALGAM-FOUR OR MORE SURFACES PERMANENT	0	4261	OSSEOUS GRAFT	40
2330/2385	RESIN-ONE SURFACE ANTERIOR/POSTERIOR	0	4262	OSSEOUS GRAFT, MULTIPLE	50
2331/2386	RESIN-TWO SURFACES ANTERIOR/POSTERIOR	0	4268	GUID TISSUE REGENERATION INCLUDING SURGERY	60
2332/2387	RESIN-THREE SURFACES ANTERIOR/POSTERIOR	0	4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	60
2335	RESIN-THREE SURFACES OR INVOLVING INCISAL ANGLE - ANTERIOR	0	4271	FREE SOFT TISSUE GRAFT & DONOR SITE SURGERY	70
			4320	PROVISIONAL SPLINTING - INTRACORONAL	20
			4321	PROVISIONAL SPLINTING - EXTRACORONAL	20
			4341	PERIODONTAL ROOT PLANING - PER QUADRANT	30
			4355	FULL MOUTH DEBRIDEMENT BEFORE COMPREHENSIVE TRTMT (NOTE A)	15
			4381	LOCAL DELIV CHEMOTHERAPY AGENTS (PREAUTHORIZATION REQ)	20
			4910	PERIODONTAL MAINTENANCE AFTER ACTIVE THERAPY (NOTE B)	10
MAJOR RESTORATIVE (CROWNS)			PROSTHETICS REMOVABLE (DENTURES)		
2510	INLAY-METALLIC-ONE SURFACE	135	5110	COMPLETE DENTURE - UPPER	235
2520	INLAY-METALLIC-TWO SURFACES	150	5120	COMPLETE DENTURE - LOWER	235
2530	INLAY-METALLIC-THREE SURFACES	180	5130	IMMEDIATE DENTURE - UPPER	255
2540	ONLAY-METALLIC-PER TOOTH (ADDITION TO INLAY)	120	5140	IMMEDIATE DENTURE - LOWER	255
2610	INLAY-PORCELAIN/CERAMIC-ONE SURFACE	170			
2620	INLAY-PORCELAIN/CERAMIC-2 SURFACES	180			
2630	INLAY-PORCELAIN/CERAMIC-3 SURFACES	190			
2640	ONLAY-PORCELAIN/CERAMIC-PER TOOTH-INLAY	100			
2650	INLAY-COMPOSITE/RESIN - 1 SURFACE (LABORATORY PROCESSED)	150			
2651	INLAY-COMPOSITE/RESIN - 2 SURFACES (LABORATORY PROCESSED)	160			
2652	INLAY-COMPOSITE/RESIN - 3 OR MORE SURFACES (LAB PROCESSED)	170			
2710	CROWN-RESIN-LABORATORY	80			
2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	230			
2750	CROWN-PORCELAIN FUSED TO HI NOBLE METAL	220			
2751	CRWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	195			
2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	210			



DENTAL

ADA CODE	PROCEDURE NAME	MEMBER PAYS	ADA CODE	PROCEDURE NAME	MEMBER PAYS
PROSTHETICS REMOVABLE (DENTURES) Continued			ORAL SURGERY (EXTRACTIONS)		
5211	UPPER PARTIAL DENTURE-RESIN BASE INCLUDING CLASP	210	7110	SINGLE TOOTH	10
5212	LOWER PART DENTURE-RESIN BASE INCLUDING CLASP	210	7120	EACH ADDITIONAL TOOTH	10
5213	UPPER PARTIAL DENTURE-METAL BASE, RESIN SDL INCL CLASP	260	7130	ROOT REMOVAL-EXPOSED ROOTS	10
5214	LOWER PARTIAL DENTURE-METAL BASE, RESIN SDL INCL CLASP	260	7210	SURGICAL REMOVAL OF ERUPTED TOOTH	20
5281	UNILATERAL PARTIAL DENTURE-METAL BASE, CAST CLASP	140	7220	REMOVAL OF IMPACTED TOOTH-SOFT TISSUE	25
5410	ADJUST DENTURE-COMPLETE/PARTIAL, UPPER/LOWER	12	7230	REMOVAL OF IMPACTED TOOTH-PARTIALLY BONY	30
5510	REPAIR BROKEN COMPLETE DENTURE BASE	27	7240	REMOVAL OF IMPACTED TOOTH-COMpletely BONY	40
5520	REPLACE MISSING/BROKEN TOOTH-COMPLETE DENTURE-EACH TOOTH	22	7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS-CUTTING PROCED	20
5610	REPAIR ACRYLIC SADDLE OR BASE	25	7260	OROANTRAL FISTULA CLOSURE	55
5620	REPAIR CAST FRAMEWORK	30	7270	TOOTH REPLANATION	30
5630	REPAIR OR REPLACE BROKEN CLASP	29	7280	SURGICAL EXPOSURE IMPACTED/UNERUPTED TOOTH-ORTHODONTIC	45
5640	REPLACE BROKEN TEETH-PER TOOTH	22	7281	SURGICAL EXPOSURE IMPACTED/UNERUPTED TOOTH-TO AID ERUPT	35
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	28	7285	BIOPSY OF ORAL TISSUE-HARD **	20
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	35	7286	BIOPSY OF ORAL TISSUE-SOFT **	25
5710	REBASE DENTURE-COMPLETE/ PARTIAL, UPPER OR LOWER	90	7291	TRANSSEPTAL FIBEROTOMY	6
5730	RELINE DENTURE-COMPLETE/PARTIAL, UPPER OR LOWER-CHAIRSIDE INOTE C1	50	7310	ALVEOLOPLASTY IN CONJUNCTION W/EXTRACTIONS-PER QUADRANT	20
5750	RELINE DENTURE-COMPLETE/PARTIAL, UPPER OR LOWER-LAB (NOTE C1)	70	7320	ALVEOLOPLASTY NO EXTRACTIONS-PER QUADRANT	30
5820	TEMPORARY PARTIAL STAYPLATE-UPPER OR LOWER	95	7470	REMOVAL EXOSTOSIS-MAXILLA OR MANDIBLE	45
5850	TISSUE CONDITIONING UPPER - DENTURE	27	7510	INCISION & DRAINING OF ABSCESS-INTRAORAL SOFT TISSUE	15
5851	TISSUE CONDITIONING LOWER - DENTURE	25	7910	SUTURE SIMPLE WOUNDS UP TO 5CM	8
PROSTHETICS FIXED (BRIDGES)			7960	FRENULOTOMY (FRENECTOMY/FRENOTOMY) SEPARATE PROCEDURE	35
6210	PONTIC-CAST HIGH NOBLE METAL	215	7970	EXCISION OF HYPERPLASTIC TISSUE-PER ARCH	25
6211	PONTIC-CAST PREDOMINANTLY BASE METAL	185	7971	EXCISION OF PERICORONAL GINGIVA	15
6212	PONTIC-CAST NOBLE METAL	190	ORTHODONTICS*		
6240	PONTIC-PORCELAIN FUSED TO HI NOBLE METAL	215	8070	ORTHODONTIC FULLY BANDED (2 YR) CASE - TRANSITIONAL DENTITION	1,725
6241	PONTIC-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	190	8080	ORTHODONTIC FULLY BANDED (2 YR) CASE - CHILD*	1,725
6242	PONTIC-PORCELAIN FUSED TO NOBLE METAL	205	8090	ORTHODONTIC FULLY BANDED (2 YR) CASE - ADULT*	2,125
6520	INLAY-METALLIC-TWO SURFACES	150	ADDITIONAL PROCEDURES		
6530	INLAY-METALLIC-3 OR MORE SURFACES	180	9110	PALLIATIVE TREATMENT	5
6540	ONLAY - METALLIC PER TOOTH - INLAY	120	9210	LOCAL ANESTHESIA	0
6545	RTAIN-CAST METAL FOR RESIN BONDED FIXED PROSTHESIS	80	9220	GENERAL ANESTHESIA-FIRST 30 MINUTES	30
6750	CROWN-PORCELAIN FUSED TO HI NOBLE METAL	220	9221	GENERAL ANESTHESIA-EACH ADDITIONAL 15 MIN	9
6751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	195	9230	ANALGESIA	4
6752	CROWN-PORCELAIN FUSED TO NOBLE METAL	210	9240	INTRAVENOUS SEDATION PER 1/2 HOUR	25
6780	CROWN-3/4 CAST HIGH NOBLE METAL	205	9310	CONSULTATION (DIAGNOSTIC SVC BY NONTREATING PRACTITIONER)	10
6790	CROWN-FULL CAST HIGH NOBLE METAL	215	9910	APPLICATION OF DESENSITIZING MEDICAMENT	3
6791	CROWN-FULL CAST PREDOMINANTLY BASE METAL	195	9940	OCCUSAL GUARDS BY REPORT	50
6792	CROWN-FULL CAST NOBLE METAL	205	9951	OCCUSAL ADJUSTMENT-LIMITED	10
6930	RECEMENT BRIDGE	22	9952	OCCUSAL ADJUSTMENT-COMPLETE	45
			9980	STERILIZATION SURCHARGE (PER VISIT)	5
			9990	AFTER HOURS SURCHARGE	25
			9999	BROKEN APPOINTMENT FEE (PER 1/2 HOUR)	15

FOOTNOTES:

Note: Procedures not shown are not covered by the dental plan.

NOTE A: Procedure 4355 (Full Mouth Debridement) - Limited to once per 36 months.

NOTE B: Procedure 4910 (Perio Maintenance After Active Therapy) - Limited to twice; must be within 12 months after osseous surgery.

NOTE C: Procedures 5730 and 5750 (Reline Dentures) - Limited to once per 36 months.

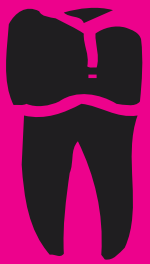
** - Lab fees for biopsies and excisions are to be paid by the patient.

* - Orthodontics for patients 19 and under at the time of banding are covered at the CHILD copayment.

Orthodontics for patients 20 and over at the time of banding are covered at the ADULT copayment. Treatment beyond 24 months is the responsibility of the patient. ORTHODONTIC treatment related to TMJ dysfunction is not covered. Patient pays an additional \$250 for records..

Questions regarding plan benefits and features should be directed to DBP Customer Service at 1-877-566-3562.

Pedodontist care is excluded. Plan offers a 20% discount off the Pedodontist's charges.



DENTAL

United Concordia DHMO Schedule of Benefits

- This Schedule of Benefits contains additional services that are effective January 1, 2002.
- The member must select a participating provider site from which to receive in-network benefits.
- Members may transfer participating provider sites at any time. There is no limit to the number of changes allowed per year.
- Changes made after the 10th of the month are effective the 1st of the following month.
- Members must be referred to participating specialist sites by their participating provider site to receive in-network specialist benefits.
- The Company will allow referral of a member to a non-network specialist if all of the following conditions are met:
 - (1) The member is diagnosed with a condition or disease that requires specialized care;
 - (2) The Company does not have a specialist in its panel with the training and expertise to treat the condition or disease;
 - (3) The member will be liable only for the applicable copayment, as indicated on the Schedule of Benefits.
- In the case of an accident or emergency involving acute pain or a condition requiring immediate treatment (but not hospitalization), occurring more than fifty (50) miles from the Member's home, the Dental Plan covers the cost of all necessary diagnostic and therapeutic dental procedures administered by a general dentist up to \$50 for each accident or emergency, subject to the member's copayment.

ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS	ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS
Clinical Oral Examinations			Crowns - Single Restoration		
0120	Periodic Oral Evaluation	\$0.00	2710	Crown - Resin (laboratory)	\$64.00
0140	Limited Oral Evaluation - Problem Focused	0.00	2740	Crown - porcelain/ceramic substrate	225.00
0150	Comprehensive Oral Evaluation	0.00	2750	Crown - porcelain fused to high noble metal	230.00
0170	Re-evaluation - Limited, Problem Focused (eff. 01/2002)	0.00	2751	Crown - porcelain fused to predom. base metal	215.00
Radiographs			2752	Crown - porcelain fused to noble metal	225.00
0210	Intraoral - Complete Series (incl. Bitewings)	\$0.00	2780	Crown - 3/4 cast high noble metal (eff. 01/2002)	190.00
0220	Intraoral - Single Film	0.00	2781	Crown - 3/4 cast predominately base metal (eff. 01/2002)	190.00
0230	Intraoral - Each Add'l Film	0.00	2782	Crown - 3/4 cast noble metal (eff. 01/2002)	190.00
0240	Intraoral - Occlusal Film	0.00	2783	Crown - 3/4 porcelain/ceramic (eff. 01/2002)	190.00
0270	Bitewings - Single Film	0.00	2790	Crown - full cast high noble metal	190.00
0272	Bitewings - 2 Films	0.00	2791	Crown - full cast predominately base metal	215.00
0274	Bitewings - 4 Films	0.00	2792	Crown - full cast noble metal	220.00
0277	Bitewing - 7 to 8 films (eff. 01/2002)	0.00	Other Restorative Services		
0330	Panoramic X-Ray	0.00	2910	Recement inlay	15.00
0340	Cephalometric Film	0.00	2920	Recement crown	15.00
Tests & Lab Examinations			2930	Prefabricated stainless steel crown (Prim. Tooth)	48.00
0460	Pulp Vitality Tests	\$0.00	2931	Prefabricated stainless steel crown (Perm. Tooth)	56.00
0470	Diagnostic Casts	0.00	2940	Sedative filling	0.00
Dental Prophylaxis			2950	Core buildup, including pins	90.00
1110	Prophylaxis (Cleaning) - Adult (1 per 6 months)	\$0.00	2951	Pin retention - per tooth in addition to restoration	10.00
1120	Prophylaxis (Cleaning) - Child (1 per 6 months)	0.00	2952	Cast post & core in addition to crown	90.00
Topical Fluoride Treatment			2953	Each additional cast post - same tooth (eff. 01/2002)	45.00
1203	Topical App. of Fluoride Tx - Child (exclude prophyl)	\$0.00	2954	Prefabricated post & core in addition to crown	90.00
1204	Topical App. of Fluoride Tx - Adult (exclude prophyl)	0.00	2957	Each add'l prefabricated post-same tooth (eff. 01/2002)	45.00
Other Preventive Services			Pulp Capping		
1330	Oral Hygiene Instruction	\$0.00	3110	Pulp Cap - Direct (excluding final restoration)	\$0.00
1351	Sealant - Per Tooth (Child)	0.00	3120	Pulp Cap - Indirect (excluding final restoration)	0.00
Space Maintenance (Passive Appliances)			Pulpotomy		
1510	Space Maintainer - Fixed Unilateral	\$0.00	3220	Therapeutic Pulpotomy	25.00
1515	Space Maintainer-Fixed Bilateral	0.00	3221	Gross pulpal debridement (eff. 01/2002)	15.00
1520	Space Maintainer-Removable Unilateral	0.00	3230	Pulpal Therapy (resorbable filling) - anterior primary (excluding final restoration)	40.00
Amalgam Restorations (Incl. Local Anesthesia & Polishing)			3240	Pulpal Therapy (resorbable filling) - posterior primary (excluding final restoration)	55.00
2110	Amalgam - one surface, primary	\$0.00	Root Canal Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)		
2120	Amalgam - two surfaces, primary	0.00	3310	Anterior (excluding final restoration)	\$90.00
2130	Amalgam - three surfaces, primary	0.00	3320	Bicuspid (excluding final restoration)	120.00
2131	Amalgam - four or more surfaces, primary	0.00	3330	Molar (excluding final restoration)	165.00
2140	Amalgam - one surface, permanent	0.00	Retreatment (Including Root Canal Therapy)		
2150	Amalgam - two surfaces - permanent	0.00	3346	Retreatment of previous root canal therapy - anterior	\$165.00
2160	Amalgam - three surfaces - permanent	0.00	3347	Retreatment of previous root canal therapy - bicuspid	195.00
2161	Amalgam - four or more surfaces, permanent	0.00	3348	Retreatment of previous root canal therapy - molar	240.00
Resin Restorations (Incl. Local Anesthesia)			Periapical Services		
2330	Resin - one surface, anterior	\$0.00	3410	Apicoectomy/Periradicular surgery - anterior	\$107.00
2331	Resin - two surfaces, anterior	0.00	3421	Apicoectomy/Periradicular surgery - bicuspid 1st root	107.00
2332	Resin - three surfaces, anterior	0.00	3425	Apicoectomy/Periradicular surgery - molar 1st root	107.00
2335	Resin - four or more surfaces or involving incisal angle	70.00	3426	Apicoectomy/Periradicular surgery - (each add'l root)	41.00
2380	Resin - one surface, posterior, primary	30.00	3450	Root amputation - per root	50.00
2381	Resin - two surfaces, posterior, primary	32.00	Other Endodontic Procedures		
2382	Resin - three or more surfaces, posterior, primary	48.00	3920	Hemisection - incl. any root removal but not root canal therapy	\$41.00
2385	Resin - one surface, posterior, permanent	36.00	Surgical Services (Including Usual Postoperative Services)		
2386	Resin - two surfaces, posterior, permanent	50.00	4210	Gingivectomy per quadrant	\$125.00
2387	Resin - three surfaces, posterior, permanent	60.00	4211	Gingivectomy or Gingivoplasty/Per Tooth	\$50.00
2388	Resin - four or more surfaces, posterior, permanent	70.00	4220	Gingival curettage, surgical, per quadrant	45.00
Inlay Restorations			4240	Gingival flap, including root planing, per quadrant	135.00
2510	Inlay - metallic one surface	\$60.00	4245	Apically repositioned flap (eff. 01/2002)	110.00
2520	Inlay - metallic two surfaces	100.00	4249	Clinical crown lengthening - hard tissue	105.00
2530	Inlay - metallic three or more surfaces	120.00			
2542	Onlay - metallic - two surfaces (eff. 01/2002)	20.00			
2543	Onlays - metallic - three surfaces	30.00			
2544	Onlays - metallic - four or more surfaces	50.00			



DENTAL

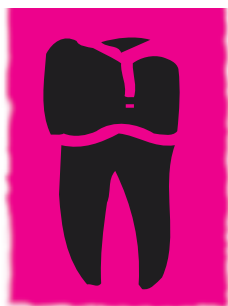
ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS	ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS
Surgical Services (Including Usual Postoperative Services) (Continued)			Bridge Retainers - Crowns		
4260	Osseous Surgery - per quadrant (including flap entry & closure)	210.00	6740	Crown - porcelain, ceramic (eff. 01/2002)	\$215.00
4263	Bone Replacement Graft	115.00	6750	Crown-porcelain fused to high noble metal	230.00
4271	Free soft tissue graft procedure - per tooth (including donor site)	100.00	6751	Crown-porcelain fused to predominantly base metal	215.00
4274	Distal or proximal wedge	45.00	6752	Crown-porcelain fused to noble metal	220.00
Adjunctive Periodontal Services			6790	Crown-full cast high noble metal	230.00
4320	Provisional splinting - intracoronal per tooth	\$40.00	6791	Crown-full cast predominantly base metal	215.00
4321	Provisional splinting - extracoronal per tooth	40.00	6792	Crown-full cast noble metal	220.00
4341	Periodontal scaling & root planing - per quadrant	50.00	Other Fixed Prosthetic Services		
4355	Full mouth debridement (one in 24 months)	50.00	6930	Recement bridge	\$17.00
Other Periodontal Services			Extractions (Including Local Anesthesia and Routine Postoperative Care)		
4910	Periodontal maintenance (following active therapy)	\$25.00	7110	Single tooth	\$17.00
Complete Dentures (Including Routine Post-Delivery Care)			7120	Each additional tooth	14.00
5110	Complete denture - maxillary	\$220.00	7130	Root removal - exposed roots	20.00
5120	Complete denture - mandibular	220.00	Surgical Extractions - (Including Local Anesthesia & Routine Postoperative Care)		
5130	Immediate denture - maxillary	240.00	7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	
5140	Immediate denture - mandibular	240.00	7220	Removal of impacted tooth - soft tissue	45.00
Partial Denture (Including Routine Post-Delivery Care)			7230	Removal of impacted tooth - partially bony	55.00
5211	Maxillary Partial Dentures Resin Base- Upper (incl. any conventional clasps, rests & teeth)	\$145.00	7240	Removal of impacted tooth - completely bony	65.00
5212	Mandibular Partial Dentures Resin Base- Lower (incl. any conventional clasps, rests & teeth)	145.00	7241	Removal of impacted tooth - completely bony with unusual surgical complications	80.00
5213	Maxillary Partial Dentures Cast Base- Upper (incl. any conventional clasps, rests & teeth)	225.00	7250	Surgical removal of residual tooth roots (cutting procedure)	35.00
5214	Mandibular Partial Dentures Cast Base- Lower (incl. any conventional clasps, rests & teeth)	225.00	Other Surgical Procedures		
5281	Removable Unilateral Partial Denture One Piece Cast Metal (incl. clasps & pontics)	65.00	7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including ortho. attachments)	\$65.00
Adjustments to Removable Prosthesis			7285	Biopsy of oral tissue-hard (bone, tooth)	35.00
5410	Adjust complete denture - maxillary	\$7.00	7286	Biopsy of oral tissue-soft (all others)	28.00
5411	Adjust complete denture - mandibular	7.00	7310	Alveoloplasty - in conjunction w/extraction per quad	23.00
5421	Adjust partial denture - maxillary	7.00	7320	Alveoloplasty - not in conjunction w/extraction per quadrant	30.00
5422	Adjust partial denture - mandibular	7.00	7450	Surgical excision - cyst	60.00
Repairs to Complete and Partial Dentures			7471	Remove Exostosis	60.00
5510	Repair broken complete denture base	\$21.00	7510	Incision & drainage of abscess - intraoral	\$35.00
5520	Replace missing/broken teeth (complete denture) - each tooth	28.00	7960	Frenulectomy (frenectomy or frenotomy)-sep.proc.	\$53.00
5610	Repair resin denture base	23.00	Orthodontics		
5620	Repair cast framework	33.00	8010	Limited Ortho. Treatment - primary dentition	\$380.00
5630	Repair/replace broken clasp	23.00	8020	Limited Ortho. Treatment - transitional dentition	405.00
5640	Replace broken teeth - per tooth	18.00	8030	Limited Ortho. Treatment - adolescent dentition	430.00
5650	Add tooth to existing partial denture	23.00	8040	Limited Ortho. Treatment - adult dentition	455.00
5660	Add clasp to existing partial denture	33.00	8050	Interceptive - primary dentition	650.00
Denture Rebase Procedures			8060	Interceptive - transitional dentition	750.00
5710	Rebase complete maxillary denture	\$55.00	8070	Comprehensive - transitional	1,650.00
5711	Rebase complete mandibular denture	55.00	8080	Comprehensive - adolescent	1,700.00
5720	Rebase maxillary partial denture	48.00	8090	Comprehensive - adult	1,750.00
5721	Rebase mandibular partial denture	48.00	Minor Treatment to Control Harmful Habits		
Denture Reline Procedures			(Includes appliance and 6 months of treatment prior to comprehensive ortho treatment).		
5730	Reline complete maxillary (chairside)	\$40.00	8210	Removable appliance therapy (6 months)	\$390.00
5731	Reline complete mandibular (chairside)	40.00	8220	Fixed appliance therapy (6 months)	370.00
5740	Reline partial maxillary (chairside)	40.00	Other Orthodontic Services		
5741	Reline partial mandibular (chairside)	40.00	8660	Pre-orthodontic treatment visit	\$75.00
5750	Reline complete maxillary (laboratory)	55.00	8670	Periodic orthodontic visit (beyond 24 months)	65.00
5751	Reline complete mandibular (laboratory)	55.00	8680	Orthodontic retention	150.00
5760	Reline maxillary partial denture (laboratory)	55.00	Unclassified Treatment		
5761	Reline mandibular partial denture (laboratory)	55.00	9110	Palliative (emergency) treatment of dental pain, minor procedures	\$15.00
Other Removable Prosthetic Services			Professional Consultation		
5810	Interim complete temporary denture - maxillary	\$125.00	9310	Consultation - per session (Consultation by Specialist or Pre-Authorized second opinion by Dental Plan)	\$20.00
5811	Interim complete temporary denture - mandibular	125.00	Professional Visits		
5820	Interim partial temporary denture - maxillary	105.00	9400	Broken appointment chg. - per 15 min. (without 24 hr notice)	\$10.00
5821	Interim partial temporary denture - mandibular	105.00	9440	Office Visit (after hours)	30.00
5850	Tissue conditioning - maxillary	25.00	Miscellaneous Services		
5851	Tissue conditioning - mandibular	25.00	9630	Medicinal Irrigation	\$20.00
Bridge Pontics			9951	Occlusal Adjustment - Limited (fewer than 12 teeth)	20.00
6210	Pontic-cast high noble metal	\$230.00	9952	Occlusal Adjustment - Complete	45.00
6211	Pontic-cast predominantly base metal	215.00	Child (Age 12 or under)		
6212	Pontic-cast noble metal	220.00	Adult (Ages 13 +)		
6240	Pontic-porcelain fused to high noble metal	230.00			
6241	Pontic-porcelain fused to predominantly base metal	215.00			
6242	Pontic-porcelain fused to noble metal	220.00			
6245	Pontic - porcelain, ceramic (eff. 01/2002)	215.00			

NON-COVERED SERVICES

- Please note that only the services listed on this Schedule of Benefits are covered. If a service is not listed, it is not covered and the member is responsible for the full fee charged by the dentist.
- Please refer to your Benefit Guide and to the Exclusions and Limitations in addition to this Schedule of Benefits for a complete description of your plan.
- Services for injuries and conditions which are covered by Worker's Compensation for employees liability laws.
- Services that cannot be performed because of the general health of the patient.

- Procedures performed which are cosmetic, elective, experimental or investigative in nature. Experimental or Investigative is defined as the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company relying on the advice of the the general dental community which includes, but is not limited to dental consultants, dental journals and/or government regulations, determines are not acceptable dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval for which approval has not been granted at the time the services were rendered. Please refer to the Exclusions and Limitations Section of your Benefit Guide.

Questions regarding plan benefits and features should be directed to UCCI Customer Service at 1-888-638-3384 (1-888-MD TEETH) TTY Hearing Impaired 1-800-859-5846.



DENTAL

United Concordia DPOS Schedule of Benefits

- This Schedule of Benefits contains additional services that are effective January 1, 2002.
- The member must select a participating provider site from which to receive in-network benefits.
- Members may transfer participating provider sites at any time. There is no limit to the number of changes allowed per year.
- Changes made after the 10th of the month are effective the 1st of the following month.
- Members must be referred to participating specialist sites by their participating provider site to receive in-network specialist benefits.
- In the case of an accident or emergency involving acute pain or a condition requiring immediate treatment (but not hospitalization), occurring more than fifty (50) miles from the Member's home, the Dental Plan covers the cost of all necessary diagnostic and therapeutic dental procedures administered by a general dentist up to \$50 for each accident or emergency, subject to the member's copayment.
- Out-of-Network benefit maximum is \$1,000 per member per calendar year.

ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS	OUT-OF-NETWORK PLAN PAYS UP TO \$	ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS	OUT-OF-NETWORK PLAN PAYS UP TO \$
Clinical Oral Examinations				Crowns - Single Restoration (Continued)			
0120	Periodic Oral Evaluation	\$0.00	\$11.00	2780	Crown - 3/4 cast high noble metal (eff. 01/2002)	\$190.00	\$190.00
0140	Limited Oral Evaluation - Problem Focused	0.00	12.00	2781	Crown - 3/4 cast predominately base metal (eff. 01/2002)	190.00	190.00
0150	Comprehensive Oral Evaluation	0.00	12.00	2782	Crown - 3/4 cast noble metal (eff. 01/2002)	190.00	190.00
0170	Re-evaluation - Limited, Problem Focused (eff. 01/2002)	0.00	12.00	2783	Crown - 3/4 porcelain/ceramic (eff. 01/2002)	190.00	190.00
Radiographs				2790	Crown - full cast high noble metal	230.00	220.00
0210	Intraoral - Complete Series (incl. Bitewings)	\$0.00	\$33.00	2791	Crown - full cast predominately base metal	215.00	200.00
0220	Intraoral - Single Film	0.00	6.00	2792	Crown - full cast noble metal	220.00	210.00
0230	Intraoral - Each Add'l Film	0.00	4.00	Other Restorative Services			
0240	Intraoral - Occlusal Film	0.00	9.00	2910	Recement inlay	\$15.00	\$12.00
0270	Bitewings - Single Film	0.00	6.00	2920	Recement crown	15.00	17.00
0272	Bitewings - 2 Films	0.00	11.00	2930	Prefabricated stainless steel crown (Prim. Tooth)	48.00	48.00
0274	Bitewings - 4 Films	0.00	15.00	2931	Prefabricated stainless steel crown (Perm. Tooth)	56.00	56.00
0277	Bitewing - 7 to 8 films (eff. 01/2002)	0.00	15.00	2940	Sedative filling	0.00	20.00
0330	Panoramic X-Ray	0.00	30.00	2950	Core buildup, including pins	90.00	40.00
0340	Cephalometric Film	0.00	30.00	2951	Pin retention - per tooth in addition to restoration	10.00	7.00
Tests & Lab Examinations				2952	Cast post & core in addition to crown	90.00	60.00
0460	Pulp Vitality Tests	\$0.00	\$14.00	2953	Each add'l cast post - same tooth (eff. 01/2002)	45.00	44.00
0470	Diagnostic Casts	0.00	15.00	2954	Prefabricated post & core in addition to crown	90.00	44.00
Dental Prophylaxis				2957	Each add'l prefabricated post - same tooth (eff. 01/2002)	45.00	44.00
1110	Prophylaxis (Cleaning) - Adult (1 per 6 months)	\$0.00	\$18.00	Pulp Capping			
1120	Prophylaxis (Cleaning) - Child (1 per 6 months)	0.00	14.00	3110	Pulp Cap - Direct (excluding final restoration)	\$0.00	\$12.00
Topical Fluoride Treatment				3120	Pulp Cap - Indirect (excluding final restoration)	0.00	12.00
1203	Topical App. of Fluoride Tx - Child (exclude prophyl)	\$0.00	\$10.00	Pulpotomy			
1204	Topical App. of Fluoride Tx - Adult (exclude prophyl)	0.00	10.00	3220	Therapeutic Pulpotomy	25.00	38.00
Other Preventive Services				3221	Gross pulpal debridement (eff. 01/2002)	15.00	20.00
1330	Oral Hygiene Instruction	\$0.00	\$0.00	3230	Pulpal Therapy (resorbable filling) - anterior primary (excluding final restoration)	40.00	50.00
1351	Sealant - Per Tooth	0.00	6.00	3240	Pulpal Therapy (resorbable filling) - posterior primary (excluding final restoration)	55.00	50.00
Space Maintenance (Passive Appliances)				Root Canal Therapy (Including Treatment Plan, Clinical Procedures and Follow-up Care)			
1510	Space Maintainer - Fixed Unilateral	\$0.00	\$55.00	3310	Anterior (excluding final restoration)	\$90.00	\$143.00
1515	Space Maintainer - Fixed Bilateral	0.00	114.00	3320	Bicuspid (excluding final restoration)	120.00	167.00
1520	Space Maintainer - Removable Unilateral	0.00	35.00	3330	Molar (excluding final restoration)	165.00	231.00
Amalgam Restorations (Incl. Local Anesthesia & Polishing)				Retreatment (Including Root Canal Therapy)			
2110	Amalgam - one surface, primary	\$0.00	\$20.00	3346	Retreatment of previous root canal therapy - anterior	\$165.00	\$220.00
2120	Amalgam - two surfaces, primary	0.00	27.00	3347	Retreatment of previous root canal therapy - bicuspid	195.00	260.00
2130	Amalgam - three surfaces, primary	0.00	35.00	3348	Retreatment of previous root canal therapy - molar	240.00	320.00
2131	Amalgam - four or more surfaces, primary	0.00	41.00	Periapical Services			
2140	Amalgam - one surface, permanent	0.00	20.00	3410	Apicoectomy/Periradicular surgery - anterior	\$107.00	\$167.00
2150	Amalgam - two surfaces - permanent	0.00	27.00	3421	Apicoectomy/Periradicular surgery - bicuspid 1st root	107.00	168.00
2160	Amalgam - three surfaces - permanent	0.00	35.00	3425	Apicoectomy/Periradicular surgery - molar 1st root	107.00	168.00
2161	Amalgam - four or more surfaces, permanent	0.00	41.00	3426	Apicoectomy/Periradicular surgery - (each add'l root)	41.00	65.00
Resin Restorations (Incl. Local Anesthesia)				3450	Root amputation - per root	50.00	77.00
2330	Resin - one surface, anterior	\$0.00	\$24.00	Other Endodontic Procedures			
2331	Resin - two surfaces, anterior	0.00	36.00	3920	Hemisection - incl. any root removal but not root canal therapy	\$41.00	\$64.00
2332	Resin - three surfaces, anterior	0.00	45.00	Surgical Services (Including Usual Postoperative Services)			
2335	Resin - four or more surfaces or involving incisal angle ant.	70.00	54.00	4210	Gingivectomy per quadrant	\$125.00	\$192.00
2380	Resin - one surface, posterior, primary	30.00	24.00	4211	Gingivectomy or Gingivoplasty/Per Tooth	50.00	30.00
2381	Resin - two surfaces, posterior, primary	32.00	29.00	4220	Gingival curettage, surgical, per quadrant	45.00	69.00
2382	Resin - three or more surfaces, posterior, primary	48.00	38.00	4240	Gingival flap, including root planing, per quadrant	135.00	205.00
2385	Resin - one surface, posterior, permanent	36.00	28.00	4245	Apically repositioned flap (01/2002)	110.00	168.00
2386	Resin - two surfaces, posterior, permanent	50.00	40.00	4249	Clinical crown lengthening - hard tissue	105.00	140.00
2387	Resin - three surfaces, posterior, permanent	60.00	48.00	4260	Osseous Surgery - per quadrant (including flap entry & closure)	210.00	225.00
2388	Resin - four or more surfaces, posterior, permanent	70.00	56.00	4263	Bone Replacement Graft	115.00	75.00
Inlay Restorations				4271	Free soft tissue graft procedure - per tooth (including donor site)	100.00	154.00
2510	Inlay - metallic one surface	\$60.00	\$66.00	4274	Distal or proximal wedge	45.00	75.00
2520	Inlay - metallic two surfaces	100.00	110.00	Adjunctive Periodontal Services			
2530	Inlay - metallic three or more surfaces	120.00	132.00	4320	Provisional splinting - intracoronary per tooth	\$40.00	\$50.00
2542	Onlay - metallic - two surfaces (eff. 01/2002)	20.00	40.00	4321	Provisional splinting - extracoronary per tooth	40.00	50.00
2543	Onlays - metallic - three surfaces	30.00	50.00	4341	Periodontal scaling & root planing - per quadrant	50.00	38.00
2544	Onlays - metallic - four or more surfaces	50.00	66.00	4355	Full mouth debridement (one in 24 months)	50.00	36.00
Crowns - Single Restoration							
2710	Crown - Resin (laboratory)	\$64.00	\$64.00				
2740	Crown - porcelain/ceramic substrate	225.00	210.00				
2750	Crown - porcelain fused to high noble metal	230.00	220.00				
2751	Crown - porcelain fused to predom. base metal	215.00	200.00				
2752	Crown - porcelain fused to noble metal	225.00	210.00				



DENTAL

ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS	OUT-OF-NETWORK PLAN PAYS UP TO \$	ADA CODE#	PROCEDURE	IN NETWORK MEMBER PAYS	OUT-OF-NETWORK PLAN PAYS UP TO \$
Other Periodontal Services				Other Fixed Prosthetic Services			
4910	Periodontal maintenance (following active therapy)	\$25.00	\$31.00	6930	Recement bridge	\$17.00	\$26.00
Complete Dentures (Including Routine Post-Delivery Care)				Extractions (Including Local Anesthesia and Routine Postoperative Care)			
5110	Complete denture - maxillary	\$220.00	\$220.00	7110	Single tooth	\$17.00	\$26.00
5120	Complete denture - mandibular	220.00	220.00	7120	Each additional tooth	14.00	21.00
5130	Immediate denture - maxillary	240.00	220.00	7130	Root removal - exposed roots	20.00	25.00
5140	Immediate denture - mandibular	240.00	220.00	Surgical Extractions - (Including Local Anesthesia & Routine Postoperative Care)			
Partial Denture (Including Routine Post-Delivery Care)				7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$27.00	\$32.00
5211	Maxillary Partial Dentures Resin Base- Upper (incl. any conventional clasps, rests & teeth)	\$145.00	\$176.00	7220	Removal of impacted tooth - soft tissue	45.00	\$44.00
5212	Mandibular Partial Dentures Resin Base- Lower (incl. any conventional clasps, rests & teeth)	145.00	176.00	7230	Removal of impacted tooth - partially bony	55.00	77.00
5213	Maxillary Partial Dentures Cast Base- Upper (incl. any conventional clasps, rests & teeth)	225.00	255.00	7240	Removal of impacted tooth - completely bony	65.00	92.00
5214	Mandibular Partial Dentures Cast Base- Lower (incl. any conventional clasps, rests & teeth)	225.00	255.00	7241	Removal of impacted tooth - completely bony with unusual surgical complications	80.00	115.00
5281	Removable Unilateral Partial Denture One Piece Cast Metal (incl. clasps & pontics)	65.00	66.00	7250	Surgical removal of residual tooth roots (cutting procedure)	35.00	53.00
Adjustments to Removable Prosthesis				Other Surgical Procedures			
5410	Adjust complete denture - maxillary	\$7.00	\$23.00	7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including ortho. attachments)	\$65.00	\$100.00
5411	Adjust complete denture - mandibular	7.00	23.00	7285	Biopsy of oral tissue-hard (bone, tooth)	35.00	65.00
5421	Adjust partial denture - maxillary	7.00	23.00	7286	Biopsy of oral tissue-soft (all others)	28.00	44.00
5422	Adjust partial denture - mandibular	7.00	23.00	7310	Alveoloplasty - in conjunction w/extraction per quad	23.00	36.00
Repairs to Complete and Partial Dentures				7320	Alveoloplasty - not in conjunction w/extraction per quadrant	30.00	46.00
5510	Repair broken complete denture base	\$21.00	\$28.00	7450	Surgical excision - cyst	60.00	110.00
5520	Replace missing/broken teeth (complete denture) - each tooth	28.00	38.00	7471	Remove Exostosis	60.00	140.00
5610	Repair resin denture base	23.00	35.00	7510	Incision & drainage of abscess - intraoral	35.00	17.00
5620	Repair cast framework	33.00	81.00	7960	Frenulectomy (frenectomy or frenotomy)-sep.proc.	53.00	82.00
5630	Repair/replace broken clasp	23.00	44.00	Orthodontics			
5640	Replace broken teeth - per tooth	18.00	23.00	8010	Limited Ortho. Treatment - primary dentition	\$380.00	\$0.00
5650	Add tooth to existing partial denture	23.00	30.00	8020	Limited Ortho. Treatment - transitional dentition	405.00	0.00
5660	Add clasp to existing partial denture	33.00	46.00	8030	Limited Ortho. Treatment - adolescent dentition	430.00	0.00
Denture Relapse Procedures				8040	Limited Ortho. Treatment - adult dentition	455.00	0.00
5710	Relapse complete maxillary denture	\$55.00	\$79.00	8050	Interceptive - primary dentition	650.00	0.00
5711	Relapse complete mandibular denture	55.00	79.00	8060	Interceptive - transitional dentition	750.00	0.00
5720	Relapse maxillary partial denture	48.00	67.00	8070	Comprehensive - transitional	1,650.00	0.00
5721	Relapse mandibular partial denture	48.00	67.00	8080	Comprehensive - adolescent	1,700.00	0.00
Denture Reline Procedures				8090	Comprehensive - adult	1,750.00	0.00
5730	Reline complete maxillary (chairside)	\$40.00	\$59.00	Minor Treatment to Control Harmful Habits			
5731	Reline complete mandibular (chairside)	40.00	59.00	(Includes appliance and 6 months of treatment prior to comprehensive ortho treatment)			
5740	Reline partial maxillary (chairside)	40.00	59.00	8210	Removable appliance therapy (6 months)	\$390.00	\$0.00
5741	Reline partial mandibular (chairside)	40.00	59.00	8220	Fixed appliance therapy (6 months)	370.00	0.00
5750	Reline complete maxillary (laboratory)	55.00	77.00	Other Orthodontic Services			
5751	Reline complete mandibular (laboratory)	55.00	77.00	8660	Pre-orthodontic treatment visit	\$75.00	\$0.00
5760	Reline maxillary partial denture (laboratory)	55.00	77.00	8670	Periodic orthodontic visit (beyond 24 months)	65.00	0.00
5761	Reline mandibular partial denture (laboratory)	55.00	77.00	8680	Orthodontic retention	150.00	0.00
Other Removable Prosthetic Services				Unclassified Treatment			
5810	Interim complete temporary denture - maxillary	\$125.00	\$125.00	9110	Palliative (emergency) treatment of dental pain, minor procedures	\$15.00	\$20.00
5811	Interim complete temporary denture - mandibular	125.00	125.00	Professional Consultation			
5820	Interim partial temporary denture - maxillary	105.00	105.00	9310	Consultation - per session (Consultation by Specialist or Pre-Authorized second opinion by Dental Plan)	\$20.00	\$30.00
5821	Interim partial temporary denture - mandibular	105.00	105.00	Professional Visits			
5850	Tissue conditioning - maxillary	25.00	49.00	9400	Broken appointment chg. - per 15 min. (without 24 hr notice)	\$10.00	\$0.00
5851	Tissue conditioning - mandibular	25.00	49.00	9440	Office Visit (after hours)	30.00	30.00
Bridge Pontics				Miscellaneous Services			
6210	Pontic-cast high noble metal	\$230.00	\$220.00	9630	Medicinal Irrigation	\$20.00	\$10.00
6211	Pontic-cast predominantly base metal	215.00	200.00	9951	Occlusal Adjustment - Limited (fewer than 12 teeth)	20.00	15.00
6212	Pontic-cast noble metal	220.00	210.00	9952	Occlusal Adjustment - Complete	45.00	145.00
6240	Pontic-porcelain fused to high noble metal	230.00	220.00	Child (Age 12 or under)			
6241	Pontic-porcelain fused to predominantly base metal	215.00	200.00	Adult (Ages 13 +)			
6242	Pontic-porcelain fused to noble metal	220.00	210.00				
6245	Pontic - porcelain, ceramic (01/2002)	215.00	200.00				
Bridge Retainers - Crowns							
6740	Crown - porcelain, ceramic (eff. 01/2002)	\$215.00	\$200.00				
6750	Crown - porcelain fused to high noble metal	230.00	220.00				
6751	Crown - porcelain fused to predominantly base metal	215.00	200.00				
6752	Crown - porcelain fused to noble metal	220.00	210.00				
6790	Crown - full cast high noble metal	230.00	220.00				
6791	Crown - full cast predominantly base metal	215.00	200.00				
6792	Crown - full cast noble metal	220.00	210.00				

NON-COVERED SERVICES

- Please note that only the services listed on this Schedule of Benefits are covered. If a service is not listed, it is not covered and the member is responsible for the full fee charged by the dentist.
- Please refer to your Benefit Guide and to the Exclusions and Limitations in addition to this Schedule of Benefits for a complete description of your plan.
- Services for injuries and conditions which are covered by Worker's Compensation for employees liability laws.
- Services that cannot be performed because of the general health of the patient.

- Procedures performed which are cosmetic, elective, experimental or investigative in nature. Experimental or Investigative is defined as the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company relying on the advice of the general dental community which includes, but is not limited to dental consultants, dental journals and/or government regulations, determines are not acceptable dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval for which approval has not been granted at the time the services were rendered. Please refer to the Exclusions and Limitations Section of your Benefit Guide.

Questions regarding plan benefits and features should be directed to UCCI Customer Service at 1-888-638-3384 (1-888-MD TEETH) TTY Hearing Impaired 1-800-859-5846.



MENTAL HEALTH/ SUBSTANCE ABUSE

MENTAL HEALTH/SUBSTANCE ABUSE PLAN

General Description of Coverage

Mental Health and Substance Abuse plan coverage is available to all individuals and their dependents who carry medical plan coverage with the State of Maryland. **The State's Mental Health and Substance Abuse plan for individuals enrolled in PPO and POS medical plans is administered by APS Healthcare, Inc. (APS).** Individuals enrolled in HMO medical plans receive all mental health and substance abuse coverage through their HMO. You cannot obtain mental health and substance abuse benefits through the State if you do not enroll in a State medical plan.

You automatically have mental health and substance abuse benefits when you enroll in any of the State sponsored medical plans. However, your mental health and substance abuse benefits vary depending on the medical plan in which you are enrolled.

POS and PPO Medical Plans: If you are enrolled in a PPO or POS plan, APS administers your mental health and substance abuse benefits. No additional premium is required. The cost of your coverage is included in your medical plan premium.

HMO Medical Plan: If you are enrolled in an HMO medical plan, all of your mental health and substance abuse benefits will be provided by your HMO.

How to Receive Mental Health and Substance Abuse Benefits

HMO Medical Plan: If you are enrolled in an HMO medical plan, all mental health and substance abuse services must be authorized by your HMO. Please contact your medical plan for more details. Their phone numbers are located on the back cover of this book.

Standard Mental Health and Substance Abuse Benefits Chart for Individuals Enrolled in HMO Medical Plans (Benefits administered by your HMO medical plan)

Benefit -- If you are enrolled in an HMO, all your mental health and substance abuse benefits must be provided through your HMO. There are no mental health or substance abuse benefits if you use a non-HMO provider.	In-Network -- All of your mental health and substance abuse benefits are provided through your HMO participating providers, and must be authorized by your HMO.	Out-of-Network
Inpatient Care, including residential crisis services	100% for up to 365 days/year if approved by the HMO	Not Covered
Outpatient Care	80% for HMO-approved outpatient visits #1-5 per calendar year; 65% for HMO-approved outpatient visits #6-30 per calendar year; 50% for HMO-approved outpatient visits #31 or more per calendar year.	Not Covered

- Consult your HMO plan for more details on covered services.

Questions?

Please call your HMO.

POS and PPO Medical Plans: If you are enrolled in a POS or PPO medical plan, your mental health and substance abuse benefits are provided by APS. To maximize your benefits, you must contact APS before receiving any services. The professionals at APS will work with you to select an appropriate referral for care. Your mental health and substance abuse benefits include coverage for the following types of treatment for mental health and substance abuse:

- inpatient facility and professional services,
- partial hospitalization, and
- outpatient facility and professional services.



MENTAL
HEALTH/
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ABUSE

Standard Mental Health and Substance Abuse Benefits Chart for
Individuals Enrolled in PPO or POS Medical Plans
[Benefits administered by APS Healthcare, Inc.]

Benefit	In-Network: Care Pre- authorized	In-Network: Care Not Pre- authorized	Out-of- Network: Care Pre- authorized	Out-of Network: Care Not Pre- autho- rized	Coverage Limits
Outpatient Facility/ Office and Professional Services, including Intensive Outpatient**	80% (first 5 visits) 65% (next 25 visits) 50% (further visits) of APS's negotiated fee maxi- mum.	40% (first 5 visits) 32.5% (next 25 visits) 25% (further visits) of APS's negotiated fee maxi- mum.	40% (first 5 visits) 32.5% (next 25 visits) 25% (further visits) of APS's negotiated fee maxi- mum.	20% (first 5 visits) 16.25% (next 25 visits) 12.5% (fur- ther visits) of APS's negoti- ated fee maximum.	No limit on the number of medically necessary/ treatable visits per year. Benefit reduction if preauthorization is not obtained. No limit on out-of-pocket expenses.
Outpatient Medication Manage- ment Services	100% of APS's negoti- ated fee maximums after a \$20 copay is met.	50% of APS's negotiated fee maximum.	50% of APS's negotiated fee maxi- mums.	25% of APS's negotiated fee maxi- mums.	No limit on the number of medically necessary visits per year. Benefit reduc- tion if preauthoriza- tion is not obtained. No limit on out-of- pocket expenses.

* ALL PERCENTAGES REFER TO APS HEALTHCARE, INC.'S NEGOTIATED FEE MAXIMUMS*.
All services must be deemed medically necessary by APS Healthcare, Inc. to obtain any benefits.
** Intensive Outpatient Services (IOP) require pre-authorization regardless of in- or out-of-network provider status.

Benefit Chart continued on next page



MENTAL HEALTH/ SUBSTANCE ABUSE

Standard Mental Health and Substance Abuse Benefits Chart for Individuals Enrolled in PPO or POS Medical Plans (continued) [Benefits administered by APS Healthcare, Inc.]

Benefit	In-Network: Care Pre- authorized	In-Network: Care Not Pre- authorized	Out-of- Network: Care Pre- authorized	Out-of- Network: Care Not Pre- autho- rized	Coverage Limits
Inpatient Facility and Professional Services and Partial Hospitalization Services and residential crisis services	100% of APS's negotiated fee maximums.	Not covered	80% of APS's negotiated fee maximums.	Not covered	No benefit coverage if preauthorization is not obtained, regardless of whether provider is in-network or out-of-network. Out-of-Network Expenses: co-insurance expenses during any one inpatient stay is limited to \$1,500 per member. Member may be liable for any expenses incurred beyond allowed amounts. No limit to medically necessary and treatable preauthorized inpatient days. Sixty days per benefit period for partial hospitalization.
* ALL PERCENTAGES REFER TO APS HEALTHCARE, INC.'S NEGOTIATED FEE MAXIMUMS					
* All services must be deemed medically necessary by APS Healthcare, Inc. to obtain any benefits					

- Covered charges for mental health and substance abuse are the same.
- Substance Abuse Detoxification and Rehabilitation are covered under inpatient, partial hospitalization, or outpatient services when medically necessary.
- To receive maximum benefits, care must be preauthorized by calling APS Healthcare, Inc. at 1-877-239-1458.

Questions

What should I do in the event of an emergency?

Call the APS State of Maryland dedicated Help Line at 1-877-239-1458 for immediate assistance if you are experiencing a non-life threatening emergency or crisis. If the emergency is life threatening, you should seek treatment at the nearest emergency room. You must notify APS within 24 hours of an emergency admission to certify your care. APS staff are available 24 hours a day, seven days a week, 365 days a year.

NOTE: If you obtain services without preauthorization from APS, your benefits will be reduced by 50% for medically necessary OUTPATIENT services and you will receive no benefits for INPATIENT facility and professional service costs. You receive maximum available benefits if you receive care from an APS provider that has been preauthorized by an APS team specialist at the APS Help Line, 1-877-239-1458.





**MENTAL
HEALTH/
SUBSTANCE
ABUSE**



What happens when I call the APS Help Line?

You will speak to a APS team member, who will work with you or your covered family member to find the resources you need or to determine the appropriate treatment for your situation. APS team members include member referral and customer service representatives, and mental health professionals experienced in dealing with mental health and substance abuse problems.

Are detoxification and rehabilitation services covered?

Yes, detoxification and rehabilitation services are covered through and administered in the same manner as mental health services.

Must I get preauthorization before benefits are paid on care I receive?

Yes, for inpatient and partial hospitalization services, you must get preauthorization care in order to be eligible for benefit coverage. To preauthorize services, you or your provider must call the **APS Helpline** at 1-877-239-1458. **APS** staff are available 24 hours a day, seven days a week.

In order to receive maximum benefits for any needed outpatient care, you or your family members must preauthorize care before services are rendered. If preauthorization is not obtained, your benefit coverage will be reduced.

Must I get preauthorization for psychological testing?

Yes. Psychological testing is an excluded service under certain circumstances, such as for educational circumstances. Thus, preauthorization must be obtained in order to determine medical necessity and plan inclusion.

Must I get preauthorization for Intensive Outpatient Program services? What is the benefit?

Yes. Intensive Outpatient Program (IOP) services requires preauthorization in order to determine medical necessity for an alternative level of outpatient care. However, IOP services are covered under the outpatient benefit structure, which includes a co-insurance amount.

Can I use a non-APS provider?

Yes, you may choose to receive care from a provider not in the APS network, but please be aware of the following:

- You must call the APS Help Line for preauthorization in order to receive maximum out-of-network benefits. The APS Care Manager will discuss the case with you for preauthorization and treatment approval. **If you receive care from an out-of-network provider without preauthorization, your benefits will be reduced.**
- You will incur greater out-of-pocket expenses when you use out-of-network providers. The State of Maryland Mental Health and Substance Abuse Benefits Chart outlines the differences between out-of-network and in-network benefits reimbursement.
- The provider you choose must be a licensed practitioner and vendor-eligible as determined by State law. It is your responsibility to verify that the provider you have chosen is appropriately licensed.



MENTAL HEALTH/ SUBSTANCE ABUSE



Will I have to file claims?

IN-NETWORK SERVICES:

If you receive preauthorized services from an in-network provider, you do not have to file any claims. If you self-refer, you may have to file a claim with an itemized bill to APS for reimbursement. Please be aware that providers may include on the bill both medical and mental health services. Medical service charges must be submitted to your medical plan, and mental health charges must be submitted to APS. Please call the APS Help Line at 1-877-239-1458 for a member claim form and further information on filing claims or see form in the back section of this booklet (page 84).

OUT-OF-NETWORK SERVICES:

How to File a Claim for Out-of-Network Services Received:

1. The provider may ask you to pay the bill at the time of service. If this happens, pay the provider and submit a claim and an itemized bill to APS for reimbursement. Call the Help Line at 1-877-239-1458 for a claim form if you do not have one.
2. The itemized bill should be on the provider's letterhead stationery and should include:
 - diagnosis and type of treatment rendered (including CPT code);
 - the charges for the services performed;
 - the date of service;
 - patient's name, patient's date of birth and subscriber's Social Security number.
3. Mail your completed information to:
APS Healthcare, Inc.
SOM Claims
P.O. Box 1440
Rockville, MD 20849-1440
4. APS will send the payment for covered services directly to the subscriber address in the system. You will also receive an Explanation of Benefits (EOB) any time APS processes a claim. An EOB is not a bill: it is documentation of the action APS has taken on your claim.

May I use the EAP, even though I am enrolled in an HMO medical plan?

Yes. The EAP is a service available to all State employees, regardless of medical plan enrollment. You must be referred by your supervisor for EAP services. Employees cannot self-refer for this service.

Other Questions?

If you have any more questions concerning coverage, exclusions, or limitations, please contact APS at the phone number listed on the back cover of this book.



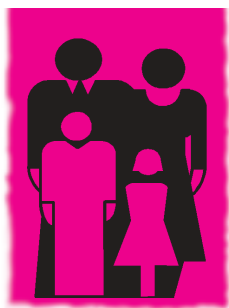
MENTAL HEALTH/ SUBSTANCE ABUSE



Exclusions:

The following is a list of excluded services. APS does not cover services and supplies:

- that are not preauthorized and medically necessary;
- not prescribed, performed, or guided by eligible practitioners;
- for inpatient treatment (or for an inpatient stay) for conditions that require only observation, diagnostic examinations, or diagnostic laboratory testing;
- for inpatient treatment that might be safely and adequately rendered in a home, provider's office, or at any lesser level of institutional care;
- that APS determines are experimental or investigative in nature or for services related to them. Experimental or investigative describes any service or supply that is judged to be experimental or investigative by APS in its sole discretion. APS will apply the following criteria to decide this: any supply or drug used must have received final approval to market by the U.S. Food & Drug Administration; there must be enough information in the peer-reviewed medical and scientific literature to let APS judge the safety and efficacy; the available scientific evidence must show a good effect on health outcomes outside of a research setting; the service or supply must be safe and effective outside a research setting as current diagnostic or therapeutic options; for lab tests and prescription drugs;
- when you are not legally obligated to pay for the charge, or where the charge is made only to insured persons;
- for telephone consultations, for failure to keep a scheduled visit, for completion of forms, or other non-medical or administrative services;
- charged through separate billings by a provider's employee normally included in such provider's charges and billed for by them;
- provided as a result of failure or refusal to obtain treatment or follow a plan of treatment prescribed or directed by a practitioner;
- that are a part of a hospital, facility, or institutional stay if the patient is discharged and readmitted to the hospital, facility, or institution within 14 days in order to qualify for insurance coverage where the patient was not previously covered;
- for travel whether or not it is prescribed by a practitioner;
- for guest meals, telephones, televisions, and other convenience items;
- for routine examinations or testing;
- for the treatment of any injury, illness, or medical condition that is not medically necessary;
- for illnesses resulting from an act of war or relating to the commission of a felony;
- for treatment of organic brain syndrome;
- for acupuncture;
- for examinations of an inpatient that are not related to the diagnosis;
- for educational or teacher's services, or separate charges by interns, residents, house physicians, or other health care professionals employed by the covered facility;
- for smoking cessation;
- for weight loss and weight management programs;
- for court-ordered treatment (unless medically necessary);
- for psychoanalysis to complete degree or residency requirements;
- for experimental treatment or treatment performed for the purposes of research;
- for marriage counseling, educational therapy, speech therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy;
- for pastoral counseling;
- for psychological testing for education purposes.



TERM LIFE



TERM LIFE INSURANCE PLAN

New Term Life Insurance Carrier Effective January 1, 2003

Effective January 1, 2003, the carrier for the State Term Life Insurance Plan will change from Metropolitan Life to Standard Insurance Company.

- Met Life members in 2002 will be automatically enrolled at the same 2002 coverage level with Standard Insurance Company effective January 1, 2003, unless the member changes coverage or cancels life insurance during Open Enrollment.
- Members who want to increase their coverage level in 2003 from the 2002 level must be approved by Standard Insurance Company, if the new amount is above \$50,000 for the employee (above \$25,000 for dependents). If Standard Insurance Company does not approve the higher amount, the life insurance coverage will remain at the 2002 level.
- Employees who are not enrolled in Met Life in 2002 may enroll with the new carrier, Standard Insurance Company, during Open Enrollment.
- New employees have 60 days from their entry on duty date to enroll in the State Term Life Plan.

What Happens on January 1, 2003 if you are Enrolled with Met Life During 2002

If you are an active employee enrolled in the State Term Life Insurance Plan with Met Life during 2002, this transfer to the new carrier, Standard Insurance Company, occurs effective January 1, 2003 as shown in the chart below:

On January 1, 2003, if you:	On January 1, 2003, your carrier is:
• are on vacation	• Standard Insurance Company
• are on holiday	• Standard Insurance Company
• are on excused absence absence not due to a disabling ailment (funeral, etc.)	• Standard Insurance Company
• at work	• Standard Insurance Company
• absent due to a nondisabling ailment, i.e., funeral, etc.	• Standard Insurance Company

On January 1, 2003, if you:	On January 1, 2003, your carrier is:
• are disabled and are on a Waiver of Premium from Met Life, or are in the process of satisfying the Waiver of Premium with Met Life for disability	• Met Life ** (see ** note)

** Your Waiver of Premium coverage will continue with Met Life until the month you reach age 65 under the same terms and conditions. You may then convert to an Individual policy with Met Life. You do not transfer over to the new carrier.



TERM LIFE



General Description of Coverage

The Term Life Insurance Plan is available to all employees and their dependents who are eligible for health benefits with the State. Employees are eligible for coverage in \$10,000 increments to a maximum of \$300,000.

You may choose up to \$50,000 in coverage without a Medical History Statement. If you select greater than \$50,000 for yourself or \$25,000 for your dependent, you must complete the Medical History Statement, which will be reviewed for approval by the plan. Medical History Statements are available from your Agency Benefits Coordinator.

Accelerated Benefit: An Accelerated Benefit is available in the event of a terminal illness. An insured employee (or insured spouse) has the option for early access to up to 50% of the face amount of their insurance coverage, if the insured person is medically certified to be terminally ill with less than six months to live, and has at least \$20,000 in coverage.

Dependent Life Insurance Coverage: Employees can elect dependent life insurance coverage up to 50% of the employee's coverage. The employee must enroll for at least \$10,000 in Employee Life Insurance coverage to be eligible for Dependent Life Insurance coverage. Certain other rules apply to dependent coverage:

- Dependent life insurance coverage is available (in \$5,000 increments), up to \$150,000 in coverage. Employees can obtain dependent life insurance for a spouse and/or child(ren).
- Dependent life insurance coverage is available up to \$25,000 without Medical Review. If you elect a higher amount of coverage, you must complete the Medical History Statement for the dependent, to be reviewed for approval by the plan. Applications for the Medical History Statement are available from your Agency Benefits Coordinator. You may also be notified by the plan to complete an additional Medical History Statement.
- The Accelerated Benefit is available for a terminally ill spouse. The spouse must be insured for at least \$20,000 to be eligible for the Accelerated Benefit option.

Retirement: Employees who retired after January 1, 1995 and were enrolled in the Term Life Insurance Plan as active employees have the opportunity to continue their group life insurance coverage at the time of retirement, subject to the age reduction schedule. Certain other rules apply when an employee retires. A Beneficiary Designation form should be on file with the plan.

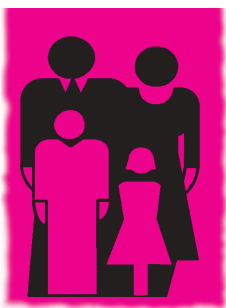
- You may continue your current coverage amount, subject to the age reduction schedule. Benefits will automatically decrease with age from the original amount.
 - 65% at age 65
 - 45% at age 70
 - 30% at age 75
 - 20% at age 80

NOTE: Premiums are adjusted according to the reduced coverage. Coverage for a Spouse and Dependents will reduce as well.

- You cannot increase your life insurance coverage.
- You can cancel your enrollment in the Term Life Insurance Plan.

Continuation of Coverage During Total Disability: After January 1, 2003, if you become totally disabled prior to age 60 and are enrolled in the State term life insurance plan on your date of disability, your coverage will continue until the ninth month of your total disability. At the ninth month, you must submit a Waiver of Premium application to the plan. If approved, your coverage will continue to age 65 and premiums will be waived. If declined, your only option for continuation of coverage is to convert to an Individual policy. Conversion applications are available from your Agency Benefits Coordinator or from the plan. Please note, Waiver of Premium applications will NOT be accepted beyond twelve months from your date of disability.





TERM LIFE



NOTE: You cannot have duplication of coverage under the life insurance plan. If you are covered as an employee, you cannot also be covered as a dependent of your spouse. If a husband and wife are both employed by the State, only one of the employees can cover dependent children, and they cannot cover each other with duplicate policies. Also, children of State employees cannot have duplicate coverage.

How to Receive Term Life Insurance Benefits

The Term Life Insurance Plan pays out 100% of the face amount of coverage upon the death of an active employee or an insured dependent. The Term Life Insurance Plan also has an Accelerated Benefit provision that allows early access to up to 50% of the face amount of coverage if the insured employee or spouse is medically certified to be terminally ill, with less than six months to live. The insured employee or spouse must be insured for at least \$20,000 to be eligible for the Living Benefit option. The named beneficiary should contact the plan in order to obtain a claim form.

Changing Coverage after Enrollment: If you are currently enrolled in the Plan, you may continue with the plan at your current coverage level each plan year without Medical Review. If you want to increase your coverage to more than \$50,000 during Open Enrollment, regardless of your current coverage amount, you must file a Medical History Statement with the plan. Applications are available from your Agency Benefits Coordinator. Please note that your increased coverage amount will become effective on the latter of: January 1, the date Standard Insurance Company approves your medical review, or the date you become "actively at work." Please note that if you drop a dependent from your coverage, it includes all coverages, including life insurance.

NOTE: For your State Term Insurance benefits coverage to begin after a new enrollment, you must be "actively at work," in the employ of the State of Maryland, and performing services for compensation on regularly scheduled working days. Regularly scheduled working days do not include holidays, non-work days, vacations, or other scheduled leaves. "Actively at work" means that you have worked at least 20 hours over the last seven consecutive calendar days and have worked at either your usual place of employment or away from your usual place of business at the agency's convenience, and that you are not currently on sick leave or other type of scheduled leave.

Conversion and Portability of Coverage: An active employee leaving State service has the option under "Portability" to continue their current coverage, along with their dependent coverage, by directly paying the plan. Conversion to a personal policy is available within 31 days of loss of coverage with the group policy. Please call the plan representative at the phone number listed on the back cover for information on conversion to non-group policies.

NOTE: MetLife Beneficiary designations will not be valid after December 31, 2002. The Standard requires a new valid Standard Insurance Company Beneficiary Designation on file. If you do not execute a new Life Insurance Beneficiary Designation Card for The Standard, your life insurance benefits will be distributed according to the order described detailed in your Standard Insurance Company Voluntary Life Insurance Employee Booklet. If you do not name a Beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the following classes: 1. Your Spouse, 2. Your Children, 3. Your Parents, 4. Your Brothers and Sisters, or 5. Your Estate. Please see your Agency Benefits Coordinator for a Standard Insurance Company Beneficiary Designation Form.

Questions?

If you have any questions about coverage, conversion policies upon termination of employment, limitations, definitions, restrictions, terminating events, or exclusions, please call the plan at the number located on the back cover of this book.

PERSONAL ACCIDENTAL DEATH AND DISMEMBERMENT PLAN

New Accidental Death and Dismemberment Carrier Effective January 1, 2003

Effective January 1, 2003, the State Accidental Death and Dismemberment Plan (AD&D) will change from American Home Assurance Company to The Metropolitan Life Insurance Company. AD&D members in 2002 will be automatically enrolled with The Metropolitan Life Insurance Company at the same 2002 coverage in 2003 with The Metropolitan Life Insurance Company effective January 1, 2003, unless the member changes the coverage level or cancels the coverage during Open Enrollment. The Metropolitan Life Insurance Company refers to their plan as the Voluntary Accidental Death & Dismemberment (VAD&D).

Principal Benefit Amount

\$100,000
\$200,000
\$300,000

General Description of Coverage

The Accidental Death and Dismemberment (AD&D) Plan is available to all active status employees and their dependents who are eligible for health benefits with the State. It is offered to State employees through the Metropolitan Life Insurance Company effective January 1, 2003. The Plan provides benefits in the event of an accidental death or dismemberment. You can choose either Employee Only coverage, or Employee and Family Coverage. The Plan offers three different levels of coverage:

Medical Review: No medical review is required for enrollment in the Plan. This Plan will cover you for accidents that occur at work as well as accidents off-the-job.

Additional Benefits: The AD&D Plan has many other benefits in the event of a covered loss. Please contact your Agency Benefits Coordinator to review the plan booklet containing a detailed description of the additional benefits. Additional benefits include:

- Exposure and Disappearance
- Waiver of Premium
- Education
- Day Care
- Seat Belt
- Common Disaster
- Emergency Evacuation
- Repatriation of Remains

Exclusions: The Plan does not cover any losses caused by or resulting from: (1) physical or mental illness, diagnosis of or treatment for the illness of, or (2) an infection, unless caused by an external wound that can be seen and which was sustained in an accident, or (3) suicide or attempted suicide, or (4) injuring oneself on purpose, or (5) the use of any drug or medicine, or (6) a war or a warlike action in time of peace, including terrorists acts, or (7) committing or trying to commit a felony or other serious crime or an assault, or (8) any poison or gas voluntarily taken, administered or absorbed, or (9) service in the armed forces or any country or international authority, except the United States National Guard, or (10) operating, learning to operate, or serving as a member of a crew of an aircraft, or (11) while in any aircraft operated by or under any military authority (other than Military Airlift Command), or (12) while in any aircraft used or designed for use beyond the Earth's atmosphere, or (13) while in any aircraft being used for a test or experimental purposes, or (14) while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation), or (15) driving a vehicle while intoxicated as defined by the laws of the jurisdiction in which the vehicle was being operated.



ACCIDENTAL
DEATH &
DISMEMBER-
MENT





ACCIDENTAL DEATH & DISMEMBER- MENT



How to Receive AD&D Plan Benefits

Benefits will be paid to the Insured Person within 365 days of the date of an accident. The Plan will pay, in one sum, a certain percentage of the Principal Benefit Amount, depending on whether there is a loss of life or some type of dismemberment. If more than one covered loss is sustained during one accident, the Plan will pay all losses up to the Principal Sum Amount.

Questions?

If you have any questions concerning coverage, limitations, or exclusions, please contact the plan at the phone number listed on the back cover of this book.

Employee Standard Benefits Chart for AD&D Plan

Loss of	Benefit
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing (both ears)	100%
Quadriplegia	100%
Paraplegia	75%
One Hand or One Foot	50%
Entire Sight of One Eye	50%
Speech or Hearing	50%
Hemiplegia	50%
Thumb and Index Finger of Same Hand	25%

If you choose Family coverage, benefits for your spouse and eligible dependent children are as follows:

Standard Dependent Benefits Chart for AD&D Plan

Dependent	Benefit
Spouse	55% of Insured Employee's Principal Benefit Amount
-and-	
Eligible Dependent Child(ren)	15% of Insured Employee's Principal Benefit Amount
If no Spouse	* Eligible Dependent Child(ren) receive 25% of Insured Employee's Principal Benefit Amount
If no Eligible Dependent Child(ren)	Spouse receives 65% of Insured Employee's Principal Benefit Amount

* Maximum benefits available per child is \$50,000.

NOTE: Please contact MetLife at the telephone number listed on the back cover of this book for an AD&D Beneficiary Designation Form. You should complete an updated AD&D Beneficiary Designation Form for the new AD&D carrier, MetLife.





**FLEXIBLE
SPENDING
ACCOUNTS**



FLEXIBLE SPENDING ACCOUNTS

General Description of Flexible Spending Accounts

Using a Flexible Spending Account can save most employees 22% to 38% of the cost of eligible out of pocket expenses for health and day care services. Each part of a Flexible Spending Account has special advantages and restrictions. You should read this section carefully. **You may want to discuss your personal situation with a tax advisor before deciding how to make a Flexible Spending Account work for you.** The State Flexible Spending Accounts are administered by **Erisa Administrative Services, Inc.**

NOTE: When you enroll in a Flexible Spending Account, you will be electing the amount per pay period regardless of the enrollment method used. There is no way to select your annual maximum. Refer to the "How to Enroll" section in this book.

Questions

What is a Flexible Spending Account?

A Flexible Spending Account takes advantage of income tax laws that allow you to pay your share of the cost of your benefits on a tax-free basis. Through a Flexible Spending Account, you "redirect" part of your pay before federal income or Social Security taxes are computed.

With a Flexible Spending Account, you don't pay federal income taxes, state income taxes or Social Security taxes on the money you use.

\$1,700	-	\$200	-	\$340	=	\$1,160
Total Monthly Taxable Salary		Flexible Contribution		Taxes (Estimated)		Take-Home Pay

Without a Flexible Spending Account, you are paying taxes on the money you use for eligible expenses. Why pay taxes on this money if you don't have to?

\$1,700	-	\$385	-	\$200	=	\$1,115
Total Monthly Taxable Salary		Taxes (Estimated)		Expenses Paid After Taxes		Take Home Pay

In this example, you save \$45 per month or \$540 per year in federal income and Social Security taxes by using a Flexible Spending Account.

How Flexible Spending Accounts Work:

Flexible Spending Accounts offer two ways to pay certain expenses with tax-free dollars.

- * Health Care Flexible Spending Account
- * Day Care Flexible Spending Account

Will a Flexible Spending Account affect my State of Maryland retirement benefits?

No, your retirement benefits are based on your salary before a Flexible Spending Account redirection.



FLEXIBLE SPENDING ACCOUNTS



Will a Flexible Spending Account affect my Group Life, Disability, and other benefits?

No, benefits for Term Life, Short and Long Term Disability, and other benefits will be based on your salary before a Flexible Spending Account redirection.

Will a Flexible Spending Account affect any other State benefit?

It may affect the amount to be redirected to your deferred compensation plan. Check with your tax advisor and/or your Agency Benefits Coordinator.

Will a Flexible Spending Account affect my Social Security benefit?

Possibly - using tax-free dollars will lower your taxable pay. If your taxable pay is below the maximum Social Security wage base, this could produce a slight reduction in your ultimate Social Security benefit when you retire. However, the savings you realize from paying for benefits with tax-free dollars should more than offset any subsequent reductions in your Social Security benefit at retirement.

You may wish to consider contributing all or a portion of your Flexible Spending Account savings to a deferred compensation plan to offset any reduction in Social Security benefits or to reduce your Flexible Spending Account participation as you near retirement.

Health Care Flexible Spending Account (HFSA)

What is a health care flexible spending account?

A health care flexible spending account (HFSA) allows you to set aside tax-free money to cover eligible health care expenses you incur for you and your eligible dependents during the plan year. To be considered a "dependent," the person must meet the IRS definition of dependent.

Using tax-free dollars to pay for eligible expenses: With the HFSA, you can set aside money to cover eligible health care expenses on a tax-free basis. This way, you save money because you never have to pay taxes on the money you set aside in the account.

Eligible health care (medical) expenses: Eligible health care (medical) expenses are expenses which are "**medically necessary**." This means the expenses must be for the diagnosis, treatment or prevention of disease and for treatment affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness.

In addition, to qualify as a reimbursable health care expense the medical, dental, vision or hearing expense must:

- * be incurred (received) during your eligible period of coverage January 1- December 31 of the plan year or dates of active employment status (please be aware that the incurred date for dental services is the impression date and that prescriptions are based upon the fill date); and
- * not be reimbursable from any other health insurance.
- * if you have any insurance benefits, you must use them before you obtain reimbursement from your HFSA.

Expenses incurred prior to or after the end of the plan year or after your eligible period of coverage (dates of active employment status) are not reimbursable.



FLEXIBLE SPENDING ACCOUNTS

Expenses (those of yourself and your dependents) that can be reimbursed: These are medically necessary and generally covered by your health insurance carrier. Some of the expenses that may be eligible for reimbursement through the HFSA if they are not paid by insurance include:

Co-insurance and deductibles	orthodontic care is prorated	Ambulance service
Physicals	over the term of the orthodon-	Bus, train, taxi or plane fare
Routine and preventive physicals	tomic contract or treatment plan;	Fees to doctors, hospitals, etc. for:
School and work physicals	submit a copy of the orthodon-	Anesthesiologist
Vision Care	tia service contract at the	Chiropractor
Ophthalmologist or Optometrist fees	beginning of every plan year.)	Christian Science practitioners
Eyeglasses	Psychiatrist	Dermatologist
Contact Lenses	Psychoanalyst (medical care only)	Neurologist
Laser Surgery	Psychologist (medical care only)	Obstetrician
Hearing care	Treatment for Alcoholism or drugs	Pathologist
Hearing aids and batteries	Sterilization	Pediatrician
Prescription drugs	Acupuncture	Podiatrist
Exclude prescription drugs for	Vaccinations	Oxygen equipment
cosmetic purposes only	Physical therapy	Wheelchair
Dental and orthodontic care	Speech therapy	Weight Loss Programs
Most dental care	Transportation essential to medical	Initiation fees and weekly
Braces, orthodontic devices	care (proof of mileage and	meetings; must have physician
necessary for proper function	medical cure required; contact	diagnosis of medical problem
of the body (Reimbursement of	Erisa for details.)	Radiologist - X-rays

Expenses that cannot be reimbursed: Expenses that are for general health or personal improvement, even if prescribed or recommended by your physician, **cannot be reimbursed.**

Cosmetic surgery such as facelifts	Humidifier purchased for dust	Wigs, when not medically necessary
and liposuction	allergy	for mental health
Some prescription drugs, even if	Health club/Swimming pool dues,	Vacuum cleaner purchased for dust
prescribed by a physician:	fees for exercise or health club	allergy
Rogaine or other growth drugs	membership even if prescribed by	Humidifier purchased for dust
Retin A or other drugs for	a physician	allergy
cosmetic use	Expenses of divorce, even when	Massage Therapy for non-specific
Other drugs for general health	doctor or Psychiatrist recommends	injury/illness
and not for specific medical	divorce	Counseling Services:
care	Non-prescription over-the-counter	Interpersonal relationship
Fees for exercise, athletic, or health	drugs	counseling,
club membership even if	Wellness or self-improvement classes	Marriage counseling, family
prescribed by a physician	LAMAZE	therapy (unless by a medical
Health insurance premiums	Maternity clothes	practitioner with a medical
Amount paid for by a separate	Diaper Service	diagnosis)
medical plan	Ear piercing or Tatooing	Dietary Foods

Please contact Customer Service at Erisa Administrative Services at 1-888-966-3539 to check eligibility of a procedure or expense. The IRS regulations do not permit the claim administrator to accept cancelled checks or cash register receipts as documentation of an expense.



FLEXIBLE SPENDING ACCOUNTS

Who is eligible to participate in an HFSA?

You are eligible to participate in an HFSA if you are otherwise eligible for health benefits with the State. Seasonal, temporary and contractual employees and graduate students are not eligible for HFSA.

Duration of participation: An election to participate or not to participate in an HFSA is irrevocable for the plan year unless you have an eligible change in family status. Complete the Flexible Spending Account section of the Enrollment Worksheet on the date the change in family status occurs or within 60 days of the qualifying event. Your eligibility is governed by the effective dates of coverage as outlined in this book.

HOW TO ENROLL

During the Open Enrollment period — if you wish to enroll in an HFSA, you must use the IVR system. If prompted by the IVR that you are not able to use this enrollment method, you must complete and file an Enrollment Worksheet before Open Enrollment ends.

After the start of the plan year — If you become eligible after the start of a new plan year, you may enroll on your date of eligibility (date of hire) or within 60 days of the qualifying event. After the qualifying event, complete and file an Enrollment Worksheet with your Agency Benefits Coordinator within 60 days. Your effective date of new coverage or a change in coverage depends upon when your payroll deductions start or change. You cannot do a Retroactive Adjustment for the Health Care Flexible Spending Account benefit.

Setting up an account: You decide how much money to set aside in an account for the plan year. You may deposit any amount between \$10 and \$250 a month (\$120 to 3,000 annually) for a full Plan year.

Health Care FSA:	Minimum	Maximum
Annually	\$120.00	\$3,000.00
Monthly (12)	\$10.00	\$250.00
Bi-weekly (24)	\$5.00	\$125.00
21 or 22-Pay-Faculty (19)*	\$6.32/pay	\$157.89/pay

*** For Year 2003, all 21 or 22-Pay Faculty members must contact the Personnel Office of their respective institutions for a Year 2003 schedule of paychecks and multiple deductions. Multiple deduction schedules differ by institution.**

After you decide how much money you want to set aside in the HFSA, complete the Flexible Spending Account section of the Enrollment Worksheet. **The amount you authorized per pay period will be redirected, before taxes, from your paycheck.**

Estimate your expenses on the conservative side: Estimating your expenses conservatively will allow you to benefit from the HFSA's tax advantage without having to forfeit any portion of your account that is not used by the end of the plan year or your period of active status employment.

Use it or lose it (forfeiture): Because of the favorable tax treatment you receive through this type of account, there is an IRS restriction that applies. The restriction states that any money remaining in your HFSA at the end of the grace period will be forfeited.



FLEXIBLE SPENDING ACCOUNTS



Using your account — filing claims: As you incur reimbursable health care expenses (for yourself and your dependents) during your eligible period of coverage, send in your claim forms and the required documentation to the claim administrator listed on the claim form. When you have claimed \$20 or more, in unreimbursed expenses (for example: deductibles, coinsurance, or expenses not covered by insurance), a benefit payment from your account will be sent to you, either by check or direct deposit. After the end of the last quarter of the plan year, claims for less than \$20 will be paid.

How often are claims paid?

Claims are processed for payment weekly. Claim requests will be processed within 10 days of receipt.

Required claim reimbursement documentation:

Include this with your claim.

- A completed (and signed) Healthcare Claim Form; and
- Explanation of Benefits (EOB) from insurance companies in which you are enrolled. File your claim with insurance first, even if you know it will not be covered. Then submit the Explanation of Benefits or denial with your claim form. This includes your vision, dental, and mental health/substance abuse claims. You may file an HFSA claim for the portion that you are required to pay after insurance reimbursement.
- Prescription receipts should include the name of the patient, the name of the prescribing physician, the name of the drug, the date the prescription was filled, the prescription number, and the charge to the patient. The copay amount should be indicated on the receipt.
- Receipts for in-network medical copays should include the name of the patient, the name and address of the doctor, the date of service, the ADA code, and the amount the patient owes for each service. Out-of-network and out-of-area dental claims must be filed with insurance first. Send the Explanation of Benefits or denial with your claim form.

Incomplete or incorrect documentation will delay processing of claims. Instructions for completing the HFSA claim form are provided on the claim form itself. For convenience, you may download a claim form at the website on the back of the book.

Claim filing grace period: The claim filing grace period is January through April 15, following the close of the plan year. Claims for Year 2003 must be postmarked no later than April 15, 2004 in order to be reimbursed.

Claims for Year 2003 received in April 2004 must be complete and correct or they will not be processed for payment or returned to you. File your claims for Year 2003 no later than March 15, 2004 to allow sufficient time to submit missing or correct documentation.

Keeping track of your account: To help you keep track of your account, you will receive a quarterly statement. This statement will show the activity in your account and keep you informed about your remaining balance. You may check your account balance and benefit payments on the website or on the voice computer by calling 1-888-237-9141.

Making changes during the plan year: An eligible change in family status (including gaining a dependent through marriage, birth, adoption or gaining legal custody of a child) will permit you to only increase your HFSA election amount, if the change is consistent with the change in family status.

If you wish to change your election amount, see your Agency Benefits Coordinator to complete and file an Enrollment Worksheet on the date the change in family status occurs or within 60 days of the qualifying event. A change in family status will require documentation (for example: marriage license, birth certificate) for verification of the event.



FLEXIBLE SPENDING ACCOUNTS



NOTE: Medical expenses that are reimbursed through your HFSA cannot be deducted on your personal income tax return.

If the HFSA is for you, here's what you can do:

- * See your Agency Benefits Coordinator, and enroll.
- * Keep this booklet for future reference.

Day Care Flexible Spending Account (DCFSA)

One of the most important issues to a working parent is child care. Not only is it difficult to find and arrange for good child care, it can be very expensive. Also, with our aging population, many people are caring for elderly or disabled dependents who are unable to care for themselves.

What is a Day Care Flexible Spending Account?

The Day Care Flexible Spending Account (DCFSA) is designed to give you a tax saving way to pay for day care expenses for your children or eligible dependents.

It is important to remember that day care expenses must meet certain IRS requirements. The expenses must be necessary for you to continue working. If married, you and your spouse must both be working, or your spouse must be a full-time student or disabled.

To be considered a "dependent," the person receiving care must be eligible to be claimed as your dependent on your federal income tax return and be either:

- * under age 13; or
- * your spouse or other dependent who is physically or mentally incapable of self-support, and who spends at least 8 hours per day in your home.

Using tax-free dollars to pay for expenses: With a DCFSA you can set aside money to cover these expenses on a tax-free basis. This way you save money because you never have to pay taxes on the money you set aside in the account. For example, if you incur \$2,000 of eligible day care expenses in a year, you could save about \$453 in federal income taxes and FICA taxes:

With A Flexible Spending Account		Without A Flexible Spending Account	
\$ 45,000	..... Salary	\$ 45,000	
— 2,000	..... Pretax Child Care		0
43,000	..... Taxable Income		45,000
— 9,740	..... Taxes*	— 10,139	
33,260	..... After-Tax Income		34,807
0	..... After-Tax Child Care		2,000
\$ 33,260	..... Take-Home pay	\$ 32,807	
This employee saved \$453 in Federal taxes by participating in a DCFSA!			

***This example assumes a 15% tax bracket, 7.65% FICA taxes and does not include Day Care Tax Credit**



FLEXIBLE SPENDING ACCOUNTS



Reimbursable day care expenses: To qualify as a reimbursable day care expense, the expense must be incurred during the plan year. Any day care expenses incurred prior to or after the plan year or outside the period of active status employment are not reimbursable.

Expenses that can be reimbursed: The following type of expenses can be paid through your DCFSA. Remember, these expenses must meet IRS requirements, and they must be necessary for you and, if married, your spouse to continue working:

- * child day care services inside your home or someone else's home
- * charges by a licensed day care facility
- * adult day care inside your home or someone else's home
- * expenses for summer day camp

NOTE: Do not include your dependents health (medical) care expenses in your DCFSA. dependents health care expenses are to be included in your Health Care Flexible Spending Account.

Expenses that cannot be reimbursed: The following are expenses that do not qualify for reimbursement:

- * day care expenses you claim on your federal income tax return (child care credit)
- * child care or babysitting services by your spouse or by someone you claim as a dependent on your federal income tax return
- * housekeeping expenses not related to day care
- * food or clothing expenses for a dependent
- * transportation expenses between your home and the place your dependent receives care
- * Kindergarten expenses and tuition costs for school-aged children
- * Charges more than 30 days in advance of the service
- * Expenses for overnight camp

The IRS regulations do not permit the claim administrator to accept cancelled checks or cash register receipts as documentation of an expense.

Who is eligible to participate: You are eligible to use a DCFSA if you are an active full-time employee. Seasonal and temporary employees and graduate students are not eligible for the DCFSA.

Duration of participation: An election to participate or not to participate in the DCFSA is irrevocable for the plan year, unless you have an eligible change in family status and complete the Flexible Spending Account section of the Enrollment Worksheet within 60 days of the qualifying event.

HOW TO ENROLL

During the Open Enrollment period — If you wish to enroll in a DCFSA, you must use the IVR enrollment system. If prompted by the IVR that you are not able to use this enrollment method, you must complete and file an Enrollment Worksheet before Open Enrollment ends. You cannot do a Retroactive Adjustment for the Day Care Flexible Spending Account benefit.

After the start of the plan year —

- * If you are a new employee or you are returning to work from leave without pay after the start of a plan year, you will have 60 days from the date of employment or return to work with the State or institution to enroll in a DCFSA.
- * If you become eligible for a DCFSA as the result of a change in family status, you have 60 days after the date the change in family status occurs to enroll in the day care account.

Your effective date of new coverage or a change in coverage depends upon when your payroll deductions start or change.



FLEXIBLE SPENDING ACCOUNTS

Important tax information:

- * Before making your decision about setting up a DCFSA, remember you may claim day care credit on your federal income tax return.
- * Your personal financial and tax situation will help determine which of the two alternatives is best for you.
- * However, there is a general rule that may help you in thinking about your decision. Generally, if your family's taxable income (after deductions) is about \$27,000 a year or less, you may find that the federal income tax credit will save you more money. On the other hand, if your family's taxable income (after deductions) is more than about \$27,000, you may save more money using the DCFSA.
- * It is possible to claim some part of the day care credit if not all of your day care expenses are paid through your DCFSA. However, the dollar limit of the expenses eligible for the credit is reduced dollar for dollar by all payments from your DCFSA.
- * You may want to get additional financial advice before deciding which alternative is best for you. More information is available in Internal Revenue Service Publication 503, "Child and Day Care Credit."

Setting up an Account: To set up a DCFSA, you must first decide how much money to set aside for the plan year. You may deposit any amount between \$10 and \$416 a month (\$120 to \$5,000 annually for a full plan year). Your maximum amount is \$208 a month if you are married filing a separate income tax return. The IRS limits the amount of money you may redirect to the smallest of:

- * your income,
- * your spouse's income, or
- * \$5,000 per family (\$2,500 if married filing separate return).

There are special IRS provisions if your spouse is a full-time student or is disabled.

After you decide how much you want to set aside in your DCFSA complete the Flexible Spending Account section of the Enrollment Worksheet. The amount you authorized will be redirected, before taxes, from each paycheck based on the chart below:

Day Care FSA:	Minimum	Maximum
Annually	\$120.00	\$5,000.00
Monthly (12)	\$10.00	\$416.67
Bi-weekly (24)	\$5.00	\$208.33
21 or 22-Pay Faculty (19)*	\$6.32/pay	\$263.15/pay

***For Year 2003, all 21 or 22-Pay Faculty Members must contact the Personnel Office of their respective institutions for a Year 2003 schedule of paychecks and multiple deductions. Multiple deduction schedules differ by institution.**

Estimate your expenses on the conservative side: Estimating your expenses conservatively will allow you to benefit from the DCFSA's tax advantages without having to forfeit a portion of your account that may not be used by the end of the plan year or during active status employment.

Use it or lose it: Because of the favorable tax treatment you receive through this type of account, there is an IRS restriction which states that any money remaining in your account at the end of the grace period will be forfeited.



FLEXIBLE SPENDING ACCOUNTS

Using your account — filing claims:

As you incur reimbursable day care expenses, send in your claim forms and required documentation to the claim administrator listed on the claim form. See the claim form for more details.

When you have claimed \$20 or more in eligible day care expenses, a benefit payment from your account will be sent to you. After the end of the last quarter of the plan year (December), unpaid claims of less than \$20 will be paid.

How often are claims paid?

Claims are processed for payment weekly. Claim requests will be processed within 10 days of receipt.

When your claim is more than your account balance: Your DCFSa is funded on a “pay-as-you-go” basis. You may only draw on funds you have accumulated in your account. If the amount of your claim is more than the balance in your account, you will receive the balance in your account. The remainder of the expense will be “pending” while your account balance builds up from subsequent paycheck deposits. As deposits are made each pay cycle, you will be reimbursed until the claim is paid in full (assuming the total amount you elected for the year is enough to pay the claim).

Claim filing grace period: The claim filing grace period is January 1 through April 15, following the close of the plan year. Claims for Year 2003 must be postmarked no later than April 15, 2004 in order to be reimbursed.

Claims for Year 2003 received in April, 2004 must be complete and correct or they will not be processed for payment or returned to you. File your claims for Year 2003 no later than March 15, 2004 to allow sufficient time to submit missing or correct documentation.

Required claim reimbursement documentation: A completed, signed, and dated Day Care Reimbursement Claim Form. Your day care provider may complete Section IV of the claim form, including signature and date. If your day care provider does not complete Section IV of the claim form, submit a receipt for the services. The receipt should include the name, address, and taxpayer identification number of the provider, the dates of service, the charge for the service, and the name of the child(ren) for whom the services are provided.

Incomplete or incorrect documentation will delay processing of claims. Instructions for completing the Day Care Reimbursement forms are on the form itself. For convenience, you may download a claim form at the website on the back of the book.

Keeping track of your account: To help you keep track of your account, you will receive a quarterly statement. This statement will show the activity in your account and keep you informed about your remaining balance. You may check your account balance and benefit payments on the website or by calling ERISA.

Making changes after the start of a plan year: An eligible change in family status will permit you to make a change to your DCFSa election or election amount, if the change is consistent with the change in family status. Below are some examples of eligible changes in family status under the DCFSa:

- * You or your spouse go to or from full-time/part-time to part-time/full-time work.
- * You gain dependents through marriage, birth or the adoption of a child, or gain legal custody of a child.
- * You lost dependents through divorce, death of spouse or child, or lost legal custody of a child.
- * Your spouse loses or gains employment.

FLEX MARYLAND HEALTHCARE REIMBURSEMENT CLAIM FORM

(Please complete this ENTIRE form)

SECTION I: Employee Data—Complete ALL items		
Employee name (Last, First, M.I.)	Social Security Number	
Mailing Address (Street Number/P.O. Box)	<input type="checkbox"/> Check here if address has changed since last claim	
City	State	ZIP Code
Employment Status (Check One): <input type="checkbox"/> Active <input type="checkbox"/> Leave Without Pay as of: <input type="checkbox"/> Terminated as of		

SECTION II: Employee Certification

Total Number of Invoices / EOB's attached: _____

Estimated Total Reimbursement Amount: _____

Complete the information below. Refer to your Maryland Benefit Guide book for ineligible expenses.

SECTION III: INSURANCE INFORMATION Please Print

Employee's Medical Plan

Employee's Dental Plan

Spouse's Medical Plan

Spouse's Dental Plan

SECTION IV: Employee Certification (Read carefully; then date and sign this form.)

I certify that the attached charges are eligible health care expenses under the Internal Revenue Code, that these charges have been incurred, and that I have not been reimbursed nor are these charges reimbursable by any other source. I also certify that I will not claim these charges as a credit on my personal income tax return. I understand that failure to **submit** claims with required documentation by April 15th following the close of the Plan Year will result in my claims not being paid and I will lose any money left in my account. **Claims must be postmarked by April 15th or received by Erisa Administrative Services by April 15th.**

Date of Signature

Employee Signature

Mail or fax this form to:
FLEX MARYLAND
Erisa Administrative Services, Inc.,
12325 Hymeadow Drive, Building 4-200
Austin, TX 78750
Phone: (512) 249-6710

Toll free 1-888-966-FLEX (3539)

Toll Free Fax 1-888-329-8711

FLEX MARYLAND DAY CARE REIMBURSEMENT CLAIM FORM

SECTION I: Employee Data—Complete ALL items		
Employee name (Last, First, M.I.)	Social Security Number	
Mailing Address (Street Number/P.O. Box)	<input type="checkbox"/> Check here if address has changed since last claim)	
City	State	ZIP Code
SECTION II: Employee Certification (Read, sign, and date)		
<p><i>Read this section carefully, sign and date this form.</i></p> <p>I certify that the charges on this form are eligible day care expenses under the Internal Revenue Code, that these charges have been incurred, and that I have not been reimbursed by any other source for these charges. I also certify that I will not claim these charges as a credit on my personal income tax return and that they do not exceed the maximum reimbursement permitted under the Internal Revenue Code. I understand that failure to submit claims with required documentation by April 15th following the close of the Plan Year will result in my claim not being paid and I will lose any money left in my account.</p> <p>Claims must be postmarked by April 15th or received by Erisa Administrative Services by April 15th.</p>		
Employee Signature	Date Signed	
SECTION III: Dependent Data		
Enter the name(s) of the dependent(s) receiving the day care services:		
Name of Dependent (Last, First, MI)	D.O.B.	Relationship to Employee
1.		
2.		
3.		
4.		
SECTION IV: Day Care Expenses and Reimbursements		
1. Total amount paid to Day Care Provider:	\$	
2. For services rendered: Beginning Date _____ through Ending Date _____		
<input type="checkbox"/> Attached is my itemized receipt from the service provider		
<input type="checkbox"/> This claim form is my receipt. My day care service provider has signed and dated this form to verify the dates of service and payment amount.		
Name of Day Care Provider:		
Mailing address of Day Care Service Provider:		
City, State ZIP Code		
Social Security or Tax ID Number:		
Signature of Provider	Date	

Mail or fax this form to:
FLEX MARYLAND
Erisa Administrative Services, Inc.,
12325 Hymeadow Drive, Building 4-200
Austin, TX 78750
Phone: (512) 249-6710

Toll free 1-888-966-FLEX (3539)

Toll Free Fax 1-888-329-8711



FLEXIBLE SPENDING ACCOUNTS



If one of these events occur and you want to change your DCFSA election or amount you must see your Agency Benefits Coordinator to complete the Flexible Spending Account section of the Enrollment Worksheet on the date the change in family status occurs or within 60 days of the qualifying event. This rule applies even if you are on leave without pay or have terminated employment. A change in family status will require documentation (for example: marriage license, birth certificate) to verify the event. Send the form to the Employee Benefits Division at the address on the back of this book.

Terminated employee: If you terminate employment and if you have a positive DCFSA balance, you may continue to submit claims for eligible expenses incurred during the period of active status employment.

If a Day Care account is for you:

- * See your Agency Benefits Coordinator and enroll.
- * Keep this booklet for future reference.



LONG TERM
CARE

VOLUNTARY LONG TERM CARE INSURANCE PLAN

General Description of Coverage

Long Term Care is the type of care received either at home or in a facility, when someone needs assistance with activities of daily living or suffers severe cognitive impairment. However, this is not medical insurance.

Eligibility: The Long Term Care Insurance plan (LTC) is offered through Unum Life Insurance Company of America. Coverage is available to all active employees and retirees and their family members, including spouses, adult children, siblings, parents (in-laws included) and grandparents (in-laws included). Active employees and their spouses will have premiums payroll-deducted. Retirees and all other family members will be direct billed for the coverage by UNUM to their home.

Medical Underwriting: Employees are medically underwritten with the exception of newly hired employees who enroll during their initial 60-day eligibility period. Medical underwriting is also required for enrollment in the Long Term Care Plan for retirees and family members of active employees and retirees. This means you must complete a UNUM Long Term Care Medical Questionnaire. UNUM will evaluate the Medical Questionnaire to determine if the person meets their criteria to be enrolled in the LTC plan.

The Plan Choices

Facility Benefit Duration	3 Years or 6 Years			
Facility Monthly Benefit Amount	\$2,500 or \$3,000 or \$4,500 or \$6,000*			
Plans	Plan 1	Plan 2	Plan 3	Plan 4
Long Term Care Facility	100%	100%	100%	100%
Assisted Living Facility	100%	100%	100%	100%
Professional Home Care	50%	50%	50%	50%
Nonforfeiture	N/A	Yes	N/A	Yes
Compound Inflation	N/A	N/A	Yes	Yes

A UNUM Long Term Care Medical Questionnaire must be completed for all active employees and all family members, except for newly hired active employees who enroll during their initial 60 day eligibility period. The plan choices in the chart above allow you to choose the plan options that best meet your needs. Please mail the completed Long Term Care Application directly to UNUM.

When Benefits Begin - you are eligible for a monthly benefit after:

- You become disabled as defined by the plan;
- You are receiving services in a Long Term Care Facility or Assisted Living Facility; or receiving professional Home Care Services;
- You have satisfied the 90-day Elimination Period; and
- A physician has certified that you are unable to perform, without substantial assistance from another individual, two or more Activities of Daily Living (ADL) for a period of at least 90 days, or that you suffer severe cognitive impairment. You will be required to submit a physician certification every 12 months.



LONG TERM CARE

ADL losses and cognitive impairment must occur after the effective date of coverage to qualify for benefits.

Activities of Daily Living (ADLs) are:

- Bathing - washing oneself by sponge bath; or in either a tub or shower, including the task of getting in or out of the tub or shower with or without equipment or adaptive devices.
- Dressing - putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
- Toileting - getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- Transferring - moving into and out of a bed, chair or wheelchair with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - the ability to maintain control of bowel or bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
- Eating - feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
- Severe Cognitive Impairment - a severe deterioration or loss in intellectual capacity, as reliably measured by clinical evidence and standardized tests in:
 - Short or long term memory;
 - Orientation to people, places or time; and
 - Deductive or abstract reasoning.

Other Definitions:

- **Benefit Duration** - the 3 year or 6 year length of time you purchase to receive benefits at the long term care facility or nursing home facility level.
- **Assisted Living Facility** - an assisted living facility is licensed by the appropriate agency (if required) to provide ongoing care and services to a minimum of 10 inpatients in one location.
- **Professional Home Care** - includes visits to your home by a Home Health Care Provider during which skilled nursing care, physical, respiratory, occupational, dietary or speech therapy, or homemaker service is provided.
- **Respite Care** - formal care provided to you for a short period of time to allow your informal caregiver a break from their caregiving responsibilities. If you are eligible for a home care monthly benefit but benefits have not yet become payable, payments will be made to you for each day you receive respite care for up to 15 days each calendar year. The amount of your payment will equal 1/30th of your home care monthly benefit for each day that you receive respite care.
- **Optional Inflation Protection (compound capped)** - your monthly benefit will increase each year on the Policy Anniversary by 5% of the original Monthly Benefit. Increases will be automatic and will occur regardless of your health and whether or not you are disabled. Your premium will not increase due to automatic increases in your Monthly Benefit.
- **Nonforfeiture Benefit (Shortened Benefit Period):** If your coverage lapses due to nonpayment of premium after your coverage has been in force for three years, you will be eligible for a Nonforfeiture Benefit. This means your coverage will continue in force with the same level of benefits, except for a reduction in your Lifetime Maximum Amount.

Questions?

If you have questions about the Long Term Care Insurance coverage, please call Unum's LTC toll-free service number at 1-800-227-4165. This number will be available through the enrollment period, Monday - Friday, 8 a.m. - 8 p.m., EST. If you are interested in enrolling in the LTC plan, Unum representatives will mail you an Enrollment Kit with further information on the Plan Choices and the cost of each Plan Choice. The enrollment kit will also include an Application Form and Medical Questionnaire.

OVERVIEW OF ADMINISTRATIVE POLICIES

The State of Maryland offers a wide range of health benefits to its employees and retirees. In order to offer such a variety of plans as well as certain pre-tax benefits, the State must comply with certain Federal and State laws and policies. The following sections give a general overview of applicable State policies and procedures that govern the State Health Benefits Program. Please refer to these sections to find the information you need to make an informed decision about health care coverage as well as how to use your coverage throughout the year. We have also included a glossary and index to further assist you in finding health benefits information in this book.

If you have any other questions concerning the State's policies, please contact your Agency Benefits Coordinator or the Employee Benefits Division.

ELIGIBILITY FOR BENEFITS

Eligible Employees

- Employees who are regularly paid salary or wages through an official State payroll center, including but not limited to: Central Payroll Bureau, Mass Transit Administration, and University of Maryland, including graduate assistants, and the University's Far East and European Divisions.
- Elected State Officials
- Registers of Wills and employees of the office of Registers of Wills
- Clerks of the Court and employees of the offices of Clerks of the Court
- State Board or Commission members who are regularly paid salary or wages and work at least 50% of the work week
- Employees of political subdivisions which participate in the State's health benefits program with the approval of the governing body
- Employees of agencies, commissions, or organizations permitted to participate in the State's health benefits program by law

Note: An active employee must work at least 50% of the normal work week to receive the full State subsidy for health benefits for the employee and eligible dependents.

Note: An active employee must enroll within 60 days of the date of hire, or otherwise wait for the next Open Enrollment period.

Eligible Dependents

- A spouse (a husband or wife who is joined in marriage to an employee by a ceremony recognized by the laws of the State of Maryland)
- An unmarried child of an employee until the end of the calendar year in which the child becomes 19. An unmarried child means:
 - A blood descendent of the first degree, (i.e., son or daughter),
 - A legally adopted child,
 - A step-child permanently residing with the employee, and supported 50% or more by the employee,
 - A child permanently residing in the employee's household, supported 50% or more by the employee, if the child is directly descended from or placed in the legal guardianship of the employee.

ADMINISTRATIVE POLICIES



BENEFITS ELIGIBILITY



BENEFITS ELIGIBILITY



- An unmarried child 19 years or older who is incapable of self-support because of mental or physical incapacity given that:
 - the condition leading to the incapacity began before the child's 19th birthday (or 25th if a full-time student),
 - the incapacity is permanent, and
 - the child resides permanently with the employee and is supported 50% or more by the employee.
- An unmarried child who is attending an accredited educational institution full-time until the end of the calendar year in which the child turns 25 or the end of the month in which the child ceases to be a full-time student, whichever occurs first.

NOTE: A husband and wife who are both State employees may NOT have duplicate coverage under any plan by covering each other under separate enrollments. Also, children of a husband and wife who are both State Employees may NOT be covered twice under both parents' plans.

Coverage for Full-Time Students Beyond Age 19

Full-time students beyond the year in which they turn 19 can be continued in the benefits program. Coverage can be continued as long as they are full-time students, through the end of the month in which they cease to be a full time student or through the end of the year in which the full-time student turns age 25, whichever comes first. For example, a full-time student who graduates in May may continue through May 31. Ineligible children who are no longer full-time students can continue their coverage in the benefits program through COBRA. Please see the Continuation of Coverage/COBRA section of this booklet for more information.

It is the responsibility of the employee to complete an Enrollment Worksheet to remove their child from their coverage when the child is no longer a full-time student. The Employee Benefits Division will process the Enrollment Worksheet to remove the child from the coverage for the next available pay period ending date.



NOTE: A full-time student must enroll and attend class for the number of credit hours per academic semester determined by the institution to be full-time status and complete the semester. It is the employee's responsibility to supply the health plan with full-time student verification for each semester. A dependent may be listed on the employee's dependent file. However, if the health plan does not have the full-time student verification, claims will not be paid out and the dependent will be terminated, if the student verification is not received in a timely manner.



NOTE: If you fail to provide the required documentation of full-time student status by the required deadline, the dependent will be terminated from your coverage, and claims will not be paid. If the dependent is enrolled full-time the next semester, you may add them back to your coverage by submitting an Enrollment Worksheet and full-time documentation within 60 days of the start of their semester.



NOTE: It is the employee's responsibility to file an Enrollment Worksheet to add or delete dependents within 60 days of any qualifying event (marriage, birth, divorce, loss of full-time status, age limitation, death, etc.). Contact your Agency Benefits Coordinator or the Employee Benefits Division if you are uncertain about any qualifying event that will impact your health benefits. Only the Employee Benefits Division can modify your benefits. Failure to delete ineligible dependents may result in disciplinary action, termination of employment, and/or criminal prosecution. IF YOU ATTEMPT TO ADD AN INELIGIBLE PERSON TO YOUR COVERAGE, OR IF YOU FAIL TO REMOVE A DEPENDENT WHO IS NO LONGER ELIGIBLE, YOU WILL ALSO BE REQUIRED TO PAY THE FULL INDIVIDUAL PREMIUM FOR THE INELIGIBLE PERSON.

Required Documentation for Dependents

Documentation is required from employees in order to enroll dependents. The following chart provides a listing of the documents needed to enroll a dependent. Photocopies are acceptable. Please see page 66 for a copy of the State Affidavit. Outside of Open Enrollment, a documented qualifying event must occur. Foreign Documents must be translated into English by an official translator other than the employee, available at any college or university.

For Spouse	For Unmarried Children	For Legal Ward or Court-Ordered Support
<div>✓ Marriage Certificate (official)</div>	<div>For Natural Child: ✓ Natural Child's Official Birth Certificate (which must include the State Employee/Retiree's name)</div>	<div>For Legal Ward: ✓ Copy of Signed Court-Appointed Guardianship Papers (Permanent Custody) ✓ State Affidavit</div>
<div>To remove a spouse from your plan outside of the Open Enrollment period: ✓ Limited Divorce, Legal Separation Decree (must be signed by a Judge or other Court Official) ✓ Divorce Decree (must be signed by a Judge)</div>	<div>For Adopted Child: ✓ Copy of legal Adoption Papers (signed by Courts.) Insurance certification prior to adoption must be requested on adoption agency letterhead, or State issued Birth Certificate, if available. ✓ For Foreign Adoptions, documentation of entry into the United States is required, in addition to the documents noted above.</div>	<div>For Court-Ordered Support: ✓ Copy of Signed Court Order requiring employee to provide support and health coverage</div>
	<div>For Step-Child: Must reside with State employee ✓ Copy of Child's Official Birth Certificate and, ✓ Copy of Marriage Certificate, and, ✓ State Affidavit and, ✓ Applicable Divorce Decree or legal Custody Papers</div>	
	<div>For Disabled Child: ✓ Provide Physician Verification of permanent disability (Verification of the disability will be required every 3 years) ✓ Official Birth Certificate</div>	
	<div>For Grandchild or other Direct Dependent of Employee: ✓ Copy of child's and grandchild's official birth certification showing line of relationship. ✓ State Affidavit</div>	
	<div>For Full-Time Student over 19 Years Old: ✓ Verification of Full-Time Student Status per semester See form in this booklet. ✓ Official Birth Certificate</div>	

BENEFITS ELIGIBILITY



Qualified Medical Child Support Orders

The Omnibus Reconciliation Act of 1993 (OBRA93) requires employers to provide benefits to dependent children and adopted children of employees/retirees under court-ordered Qualified Medical Child Support Orders (QMCSO). The main purpose of the QMCSO is to assist divorced spouses of employees/retirees in obtaining health care for dependents and reimbursement for expenses incurred for these eligible dependents. Your natural and adoptive children are eligible to be included in your coverage, regardless of where they live. If you have not been covering an eligible dependent and are ordered to do so by a QMCSO, you must complete an Enrollment Worksheet and attach a copy of the QMCSO. A QMCSO is a qualifying change, allowing you to add a dependent without waiting for Open Enrollment. The State employee must provide a written statement to the Employee Benefits Division authorizing the custodial parent to receive membership cards, EOB's, reimbursements, etc.

Contractual and Part-Time Employees

Contractual and part-time employees are eligible to enroll in the same benefits as full-time employees, with the exception of the Flexible Spending Accounts and Long Term Care. Part-time employees who work less than 50% of a regular work week and contractual employees must pay the entire cost of the plans, including the State subsidy. If you are a part-time employee, you must enroll within 60 days of your employment start date or at Open Enrollment. If you are a contractual employee, you must enroll within 60 days of your **first** contract date or at Open Enrollment. Contractual and part-time employees must follow the same participation rules as full-time employees, with the exception of the following:

- 1) The effective date of coverage cannot be changed once the Enrollment Worksheet has been processed. (A letter must be attached with the Worksheet if the employee is requesting an effective date other than the current processing date.)
- 2) Changes to coverage can only be made if you have a qualifying event according to IRS regulations (see section on Changes in Coverage) or during Open Enrollment. (Not at the time of a contract renewal).
- 3) If you leave State service, you need to notify the Employee Benefits Division in writing to receive your COBRA package.

All contractual and part-time employees will receive payment coupons at the address given on the Enrollment Worksheet, which must be included with your payment. Your benefits will be effective as of the date noted on your letter but no claims will be paid until the Employee Benefits Division receives your payment. Payments are due the 1st of every month with a 30 day grace period. All benefits are inactive until payment is received for each month. Payment may be made in advance to cover any or all coupon(s) received, but must be made in full monthly increments. If payment is not received by the end of the month, benefits will be terminated and may not be re-instated until the next Open Enrollment Period. Payment deadlines are strictly enforced.

NOTE: If you do not receive these coupons within one month of signing your Enrollment Worksheet or you change your mailing address, please contact your Agency Benefits Coordinator or the Employee Benefits Division.

Coordination of Benefits (COB)

Coordination of benefits occurs when a person has health care coverage under more than one plan. Coordination of benefits restricts the total medical expense reimbursement from more than one plan to 100 percent of the allowable medical expenses, thereby avoiding duplicate payments. It also provides the sequence in which coverage will apply when a person is insured under two plans.



BENEFITS
ELIGIBILITY

NOTE: All plans participating in the State Health Benefits Program require information from State employees or retirees on other coverage that they or their dependents may have from another health insurance carrier. Failure of the State employee or retiree to provide this information will result in their claims being rejected until the information is received. All plans enforce Coordination of Benefits rules when paying claims.

Questions?

If I am a State employee and want to cover my spouse on my coverage, and my spouse has medical plan coverage with another employer, how do we handle a claim for benefits?

Any claim for benefits must be submitted to the benefits plan that provides primary coverage. For example, if a State employee or retiree has a claim for benefits, the claim is submitted to the State plan first. If the spouse has coverage from a different employer, the spouse's claim is submitted to the spouse's employer's medical plan first. After the primary medical plan has determined what benefits will be paid, balances may be submitted to the other medical plan for review. That plan will then review the claims and make any additional payments, if necessary.

My spouse is covered under my State medical plan, but is also eligible for medical plan coverage with my spouse's employer. Must my spouse sign up for their employer's medical plan coverage?

No. You may choose to cover your spouse only under the State medical plan. If you and your spouse choose to be covered under only one plan, you must be aware that there are limitations to enrolling in the other plans at a later date. Your spouse should check with his or her employer to determine when your spouse will be eligible to enroll in that coverage, should your spouse choose to do so at a later date. Conversely, you may also choose to cover yourself and your spouse only on your spouse's medical plan. If you choose to cover your family solely under your spouse's medical plan, you will not be able to enroll in the State benefits program except during Open Enrollment unless your spouse loses his or her benefits coverage or if there is a significant change in the health coverage offered.

My spouse, who is employed by another employer, and I both cover our children under our respective medical plans. If one of our children receives medical care, under which medical plan do we file a claim?

The State benefits program follows the rules established by the National Association of Insurance Commissioners (NAIC) for Coordination of Benefits. According to the rules established by NAIC, the parents' birth dates determine the primary coverage of the children covered under both parents' plans when the parents are not divorced or separated. The responsibility for primary coverage falls to the parent having the earlier birthday in the calendar year.

NOTE: A husband and wife who are both State employees (or who are both State retirees, or who otherwise are both covered under the State Health Benefits Program), cannot have duplicate coverage under any plan by covering each other under separate enrollments. Children of a husband and wife who are both State employees or retirees cannot be covered twice under both parents' plans.

Other Questions?

If you have any other questions about eligibility, please contact your Agency Benefits Coordinator or the Employee Benefits Division at the phone number listed on the back cover of this booklet.



State of Maryland
Sworn Affidavit of Eligibility of Coverage
For Stepchildren, Grandchildren and Court-Ordered Dependents
For Participation in the State Health Benefits Program

Please complete one Affidavit for Each Dependent

Employee Name: _____
Last First MI

Social Security Number: □□□-□□-□□□□

Name of Dependent: _____
Last First MI

Date of Birth: □□-□□-□□

Dependents Social Security Number: □□□-□□-□□□□

Relationship to Employee: ☐ Stepchild
☐ Grandchild (Must be a direct decendent of the Employee)
☐ Court-Ordered Dependent (Legal Ward)

I have attached the following additional documentation to this Sworn Affidavit:

- ☐ For Stepchild: (1) Copy of State Employee's Marriage Certificate
(2) Stepchild's Birth Certificate
(3) Applicable Divorce Decree or Custody Papers
- ☐ For Grandchild: (1) Copy of Grandchild's Birth Certificate
(2) Copy of Parent's Birth Certificate (who is the child of the State Employee)
- ☐ For Court-Ordered Dependent: Copy of court papers signed by a judge or other Court Official, indicating Permanent Custody

Certification Statement

I certify and swear that the dependent listed above who is not my biological or adopted child, is permanently living in my household 100% and is fully dependent upon me for 50% or more support. I solemnly affirm under the penalties of perjury that the contents of the foregoing paper are true to the best of my knowledge, information, and belief.

Signature of Employee

Date

EFFECTIVE DATES OF COVERAGE FOR ACTIVE EMPLOYEES

Effective Dates Generally (1st or 16th of the month)

The following rules apply to determine when your coverage begins and terminates:

- **Open Enrollment** changes always have an effective date of January 1.
- **New Enrollments** have an effective date of either the 1st or the 16th of the month, depending upon the pay period for which a deduction is taken from your pay check. New employees must file an Enrollment Worksheet within 60 days of their date of hire. You **MUST** discuss the need for retroactive coverage with your Agency Benefits Coordinator when you turn in your Worksheet.
- **Changes of Coverage** have an effective date of either the 1st or the 16th of the month, depending upon the pay period when the deduction changes on your pay check. Employees have 60 days from the date of the qualifying event (i.e., birth, death, loss of full-time student status, divorce, etc.) to file an Enrollment Worksheet to make the change in their coverage. You **MUST** discuss the need for retroactive coverage with your Agency Benefits Coordinator. Ex-spouses and dependents must be taken off at the time of the qualifying event. **Only the Employee Benefits Division has authority to modify your health benefits. All notification of changes should be sent to the Employee Benefits Division.**
- **Coverage for Your Newborn.** Employees have 60 days from the date of birth to add a newborn to their coverage by filing an Enrollment Worksheet. This mandatory requirement is for all newborns, even if you already have Family coverage. If you do not add a newborn to your coverage within 60 days of the date of birth, then you must wait until the next Open Enrollment period to add your child.

Employees must submit a birth certificate as documentation of the child's eligibility, attached to the Enrollment Worksheet. If the employee does not yet have the birth certificate, then documentation from the hospital of the child's birth must be supplied. This documentation may include a copy of the newborn bracelet, footprint documentation, hospital discharge papers, etc. This documentation from the hospital of the child's birth will be accepted as **temporary documentation of the child's eligibility. However, the employee will be required to submit the proper birth certificate within 60 days of the date of receipt of the temporary documentation.**

The Enrollment Worksheet will be processed for the next available pay period ending date to begin coverage for your newborn. **In order to cover your newborn from the date of their birth, you MUST submit a Retroactive Adjustment Form to cover your newborn from the date of birth. This applies even if you already have family coverage. See your Agency Benefits Coordinator for assistance.**

NOTE: In all the above circumstances, the Employee Benefits Division must be notified in writing through an Enrollment Worksheet within 60 days of the qualifying event (i.e., birth, death, loss of full-time student status, divorce, etc.). The notification must include all necessary documentation. Employees must also file a Retroactive Adjustment within 60 days of the date of the qualifying event, to obtain coverage back to the date of this qualifying event. See your Agency Benefits Coordinator for proper forms and for assistance. Failure to delete ineligible dependents may result in disciplinary action, termination of employment, and/or criminal prosecution.

EFFECTIVE DATES OF COVERAGE



EFFECTIVE DATES OF COVERAGE



- **Termination of Coverage.** When you terminate employment, your coverage continues in effect through the end of the time period covered by your last premium deduction. **When you terminate employment, you may be eligible to continue your coverage under COBRA. Please see the COBRA section of this book for more information.**

NOTE: It is your responsibility to verify your benefits deductions on your check stub to make sure they match the coverage you requested. It is your responsibility to check your Summary Statement to make sure the benefits match the coverage you requested. You must contact your Agency Benefits Coordinator immediately if there is an error or omission in your deductions, and must report the error or omission to the Employee Benefits Division within 60 days.

Retroactive Coverage

Your effective date of new coverage or a change in coverage depends upon when your payroll deductions start or change. Under certain circumstances, you may obtain coverage back to the date of the qualifying event through a **retroactive adjustment**. See your Agency Benefits Coordinator for assistance. **You cannot retroactively fund a Flexible Spending Account for a backdated period of time.**

NOTE: You have 60 days from the date of an incorrect or missing deduction, or a qualifying event (i.e., marriage, birth of a newborn, adoption, etc.) to file for a retroactive adjustment. Retroactive adjustments are always required (mandatory) for newborns even if you already have existing family coverage, but certain changes in coverage will not impact your payroll deductions (i.e. adding a newborn when you already pay the family coverage level deduction.) Discussion with your Agency Benefits Coordinator about retroactive adjustment coverage is very important.



Payroll Deductions and Effective Dates of Coverage

The effective dates of coverage depend upon the pay period ending date for which a deduction is taken from your paycheck. The pay period ending date is shown on the check stub of each paycheck. Paychecks are given to employees approximately one week after the pay period ending date shown on the chart.

Pay Period Ending Date for Central Payroll Employees	Pay Period Covered by Deduction Premium Payments	Pay Period Ending Date for Univ. of MD Employees	Pay Period Covered by Deduction Premium Payments
01/07/2003	01/01-01/15/2003	01/11/2003	01/01-01/15/2003
01/21/2003	01/16-01/31/2003	01/25/2003	01/16-01/31/2003
02/04/2003	02/01-02/15/2003	02/08/2003	02/01-02/15/2003
02/18/2003	02/16-02/28/2003	02/22/2003	02/16-02/28/2003
03/04/2003	03/01-03/15/2003	03/08/2003	03/01-03/15/2003
03/18/2003	03/16-03/31/2003	03/22/2003	03/16-03/31/2003
04/01/2003	04/01-04/15/2003		
04/15/2003	04/16-04/30/2003	04/05/2003	04/01-04/15/2003
04/29/2003	No deductions taken	04/19/2003	04/16-04/30/2003
05/13/2003	05/01-05/15/2003	05/03/2003	05/01-05/15/2003
05/27/2003	05/16-05/31/2003	05/17/2003	05/16-05/31/2003
06/10/2003	06/01-06/15/2003	05/31/2003	No deductions taken
06/24/2003	06/16-06/30/2003	06/14/2003	06/01-06/15/2003
		06/28/2003	06/16-06/30/2003
7/08/2003	07/01-07/15/2003		
07/22/2003	07/16-07/31/2003	07/12/2003	07/01-07/15/2003
08/05/2003	08/01-08/15/2003	07/26/2003	07/16-07/31/2003
08/19/2003	08/16-08/31/2003	08/09/2003	08/01-08/15/2003
09/02/2003	09/01-09/15/2003	08/23/2003	08/16-08/31/2003
09/16/2003	09/16-09/30/2003		
09/30/2003	No deductions taken	09/06/2003	09/01-09/15/2003
10/14/2003	10/01-10/15/2003	09/20/2003	09/16-09/30/2003
10/28/2003	10/16-10/31/2003	10/04/2003	10/01-10/15/2003
11/11/2003	11/01-11/15/2003	10/18/2003	10/16-10/31/2003
11/25/2003	11/16-11/30/2003	11/01/2003	11/01-11/15/2003
12/09/2003	12/01-12/15/2003	11/15/2003	11/16-11/30/2003
12/23/2003	12/16-12/31/2003	11/29/2003	12/01-12/15/2003
		12/13/2003	12/16-12/31/2003
		12/27/2003	No deductions taken

NOTE: If you are a 21 or 22-Pay Faculty Member, your premiums are deducted on a bi-weekly basis during the school year. Multiple deductions are taken for: medical, prescription, dental, PA&D, and term life premiums, and long term care from the last paycheck you receive for the school year. Multiple deductions are not taken for contributions to a Flexible Spending Account. For Year 2003, all 21 or 22-Pay Faculty Members **MUST** contact the Personnel Office of their respective institutions for a Year 2003 schedule of paychecks and multiple deductions. Multiple deduction schedules differ by institution. Please refer to the charts in the Flexible Spending Account section of this booklet for approximate deductions for 21 or 22-Pay Faculty Members. This IRS plan does not allow changes in deferral amounts if you select the wrong amount.

EFFECTIVE DATES OF COVERAGE



EFFECTIVE DATES OF COVERAGE



Questions?

If I miss deductions for one or two pay periods, but I do not use any benefits, must I pay the missed premiums?

Yes. If you miss deductions for two pay periods, you must pay all missed premiums including the State subsidy (if applicable) or your coverage will be cancelled for the remainder of the calendar year. Missing two pay periods or less is considered a Short Term Leave of Absence. Please review the policy in the Continuation of Coverage section in this book. The Employee Benefits Division will bill you for missed deductions and any premiums. The payment deadline is strictly enforced.

If I miss deductions because I transfer between two agencies, or my benefits are cut off in error, am I covered?

You must pay any missed premiums or your coverage will be cancelled. Contact your Agency Benefits Coordinator immediately so that your coordinator can calculate your share of the premium and submit a Retroactive Adjustment Form. You are required to pay your share of the premiums at the time the Retroactive Adjustment Form is submitted.

If I miss deductions because I am a new employee, am I covered?

Coverage is effective when your benefit deductions begin. If you need services prior to the effective date of your requested coverage, your requested coverage can be effective as of the date you started work through the retroactive adjustment process. Payment for Retroactive Adjustment coverage is required within 60 days of your hire date. See your Agency Benefits Coordinator.

If I take a Leave of Absence, may I continue my benefits?

Yes, under certain circumstances, you may be eligible for continuation of coverage. Please see the Continuation of Coverage section in this book and contact your Agency Benefits Coordinator.

If I leave State service or one of my dependents becomes ineligible to continue on my benefits, what benefits are available?

For a review of benefits that are available when you terminate your State employment, or one of your dependents becomes ineligible, please see the Continuation of Coverage section of this book and contact your Agency Benefits Coordinator.

My newborn's birth certificate has not been received and it's almost the end of the 60-day period. What do I do to enroll my newborn within the 60-day period?

You must submit the Enrollment Worksheet with documentation from the hospital of the child's birth. This documentation may include a copy of the newborn bracelet, footprint documentation, hospital discharge papers, etc. This documentation from the hospital of the child's birth will be accepted as temporary documentation of the child's eligibility. However, you will be required to submit the State-issued birth certificate to the Employee Benefits Division within 60 days of the Notice of Enrollment.

Other Questions?

Please contact your Agency Benefits Coordinator for more information.

CHANGES IN COVERAGE FOR ACTIVE EMPLOYEES

The State Health Benefits Program operates as a pre-tax cafeteria benefits program under Section 125 of the Internal Revenue Service (IRS) Code for employees. The IRS regulations governing the program do not permit changes after Open Enrollment, except in very limited circumstances. Once you have elected a plan, you must stay in the selected plan, at the selected coverage level, for the full calendar year, unless there has been a qualifying event.

A qualifying event is a change in status, such as the birth of a child, loss of a dependent, marriage, or divorce. A qualifying event can also occur in cases where your spouse's employment is terminated. You have 60 days from the occurrence of the qualifying event to make changes to your benefits. The changes made, however, must be because of and consistent with the change in status that has occurred. An Enrollment Worksheet must be completed. See your Agency Benefits Coordinator.

NOTE: Mistakes in completing the Enrollment Worksheet, using the IVR and dependent enrollment system, and other errors made by the employee do not constitute administrative (State) errors under IRS regulations.

The penalty for non-compliance with the IRS regulations is the loss of tax-exempt status for both the State and the employees in the Program. Changes outside of the Open Enrollment period will be permitted only in accordance with the IRS regulations. For this reason, you are cautioned to be very careful in making your selections.

IMPORTANT INFORMATION ON DIVORCE

On the effective date of the divorce, the ex-spouse MUST be removed from benefits coverage. Ex-spouses cannot be continued on any of the benefit plans, except under COBRA coverage. It is the responsibility of the employee to complete an Enrollment Worksheet to remove an ex-spouse from their coverage as soon as they are divorced, but no later than 60 days from the date of the divorce. If you fail to remove your ex-spouse from your coverage within 60 days of your divorce, you will be required to pay the full insurance premium for your ex-spouse from the date of the divorce.

NOTE: If an employee is obligated through terms of the divorce to provide health insurance coverage for the ex-spouse, that coverage can be provided for a limited time under COBRA and Maryland law. The ex-spouse cannot be continued on the employee's State benefits coverage and cannot receive a State subsidy of premiums. After COBRA coverage expires, the ex-spouse cannot continue to participate. COBRA coverage is not subsidized by the State. Please see the Continuation of Coverage/COBRA section of this booklet for more information.

Questions?

My child is turning 19 and is not enrolled in school. Is this considered a qualifying change?

Yes. It is considered a loss of a dependent, and therefore a qualifying change, when a dependent child turns 19 and is not enrolled in school (or is not enrolled on a full-time basis) at the end of the year in which the child turns 19. The child may continue as a covered dependent through the end of the year in which the child turns 19. If your child is no longer eligible for coverage under the State Program, your child can be covered under COBRA benefits for up to 36 months. Please see the COBRA section of this book for further information.

CHANGES IN COVERAGE



CHANGES IN COVERAGE



If I obtain a Limited Divorce or Legal Separation, can I remove my spouse from my coverage?

A spouse may be removed from your coverage if you obtain a Limited Divorce (in Maryland) or Legal Separation signed by a Judge. Once removed, however, your spouse cannot be re-enrolled until the next Open Enrollment period provided they are still eligible (not divorced). You must file an Enrollment Worksheet within 60 days of the date of the court-signed document to remove your spouse from your coverage.

What if I make a mistake in my coverage or change my mind?

Under Internal Revenue Service rules, we cannot correct mistakes made by the employees at the time of enrollment. Also, we cannot allow changes unless there is a qualifying change in status. Please be very careful when selecting your coverage.

My spouse's Open Enrollment period is different from the State's. Is this a qualifying event?

Your spouse's Open Enrollment **is** a qualifying event according to Internal Revenue Service regulation governing our program. However, what changes to benefits you wish to make, need to be consistent with the change in the spouse's benefits. You must provide documentation from your spouse's employer of the benefits available prior to the Open Enrollment and the benefits available after the Open Enrollment for consideration of a change.

Under what circumstances would a refund be denied?

A refund request for any reason other than an administrative error by a State agency cannot be approved.

Examples of refund requests that will be denied include:

- An incorrect coverage level due to a dependent no longer being eligible for coverage or overage dependents who are not full-time students or disabled or failure to provide proof of full-time student status or disability as required;
- An incorrect coverage level due to the death/divorce of a spouse;
- An incorrect coverage level due to a change in Medicare status;
- Incorrect benefits due to an incorrectly completed Enrollment Worksheet or resulting from incorrect use of the IVR during the annual Open Enrollment period;
- Refunds will not be provided for multiple deductions; or
- Incorrect deductions for changes that were not made within 60 days of the qualifying event, or
- Retroactive Terminations.

If you believe you are owed a refund because of a State Agency error, you must submit a refund request in writing within 60 days of the date of the incorrect deduction. Once benefits are received after the date of ineligibility, no refunds are warranted. For all circumstances in which a coverage level must be changed, you must submit a completed Enrollment Worksheet to change the coverage level.

Can I change health plans if my physician, dentist or other provider is no longer affiliated with my current plan?

No. The State cannot guarantee the continued participation of a particular provider in any of the State plans. Providers have the ability to terminate their association with a plan or close their panel to new patients at any time. See your Agency Benefits Coordinator to make alternative selections from the appropriate plan directory of providers. If your health care provider discontinues participation in the plan, you will not be allowed to change your plan, except during Open Enrollment.

Who has the authority to modify my benefits once I have enrolled?

Only the Employee Benefits Division has the authority to modify your benefits.

Other Questions?

If you have any other questions about changes or errors in your coverage, please contact your Agency Benefits Coordinator.

CONTINUATION OF COVERAGE/LEAVE OF ABSENCE AND COBRA

If you take a leave of absence without pay (LAWP), or leave State service, or if one of your dependents becomes ineligible to continue coverage under the State Health Benefits Program, you or your dependent may be eligible to continue health benefits coverage under a variety of regulations. Please note that if you leave State service and return within the same calendar year, you can re-enroll in State benefits.

Leave of Absence Without Pay (LAWP)

If you take a leave of absence pursuant to the Family Medical LEave Act (FMLA), special rules govern the continuation of your health benefits. Contact your Agency Benefits Coordinator.

Short Term LAWP: If you are on a short term LAWP (two pay periods or less for employees who are paid bi-weekly), that is not FMLA leave, you must continue all benefits and you will be billed by the Employee Benefits Division for your missed premiums. The Employee Benefits Division will bill for missed deductions and the payment deadline is strictly enforced.

NOTE: If you fail to pay outstanding premiums within the requested time frame, your health benefits will be cancelled. You will then have to wait until the next Open Enrollment period to obtain coverage. Payment is required even if deductions resume. The State cannot double bill for deductions from your paycheck and employees cannot have a lapse in deductions.

If your short term LAWP is due to a job-related accident or injury, or an approved FMLA leave, you are entitled to a State subsidy and are responsible for the employee share of the premium only. Contact your Agency Benefits Coordinator and request your Coordinator to return the no-pay bill to the Employee Benefits Division along with a copy of the first report of accident or injury or FMLA approval, a retroactive adjustment form, and your check for your share of the premiums.

NOTE: Even if the LAWP is due to a job-related accident or injury or approved family medical leave, you must make up missed premiums within the requested time frame or your health benefits will be cancelled. Payment deadlines are strictly enforced.

Long Term LAWP: If you are on a leave of absence without pay for more than two bi-weekly pay periods, your leave is considered a long-term LAWP. If you are on an approved long-term LAWP, you may elect to continue or discontinue health insurance for the duration of the LAWP, up to a maximum of 2 years. Payment deadlines are strictly enforced.

You must complete a COBRA/LAWP Enrollment Worksheet and submit it to your Agency Benefits Coordinator. This Worksheet should be completed as soon as you know you will miss two pay periods or more. The Worksheet will not be accepted any later than 60 days after the effective date of the LAWP.

You may continue any or all health benefits options, and you may reduce your coverage level when enrolling for LAWP benefits. Otherwise, you are subject to the same limitations in changing coverage as an active employee.

When enrolled in LAWP, the employee is responsible for 100% of the premium unless the LAWP is due to a job-related accident or injury or approved family medical leave. An employee on long term LAWP due to a job-related accident or injury or family medical leave is entitled to the State subsidy. In this case, the Agency Benefits Coordinator must have the Agency Fiscal Officer complete the applicable section of the COBRA/LAWP Enrollment Worksheet. You will be billed by the Employee Benefits Division for the appropriate amount due. Payment deadlines are strictly enforced.

CONTINUATION OF COVERAGE/LEAVE OF ABSENCE/COBRA



CONTINUA-
TION OF
COVERAGE/
LEAVE OF
ABSENCE/
COBRA



NOTE: If you fail to pay any outstanding premiums within the requested time frame, your health benefits will be cancelled. You will have to wait until the next Open Enrollment period to obtain coverage.

COBRA (Continuation of Coverage)

The State Employee Health Benefits Plan is covered by the Public Health Service Act (PHSA) and the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) which are included in the PHSA. Under these provisions, you may elect to continue certain group health benefits for a time frame determined in accordance with the regulations. These benefits include: medical, prescription, vision, and dental.

NOTE: If you choose to continue your coverage under these provisions, you will be responsible for paying 100% of the premiums, plus an additional 2% of the premium to defray administrative costs. Payment deadlines are strictly enforced.

You may continue your current coverage if you meet the following conditions:

- You have a qualifying event as defined below, and
- You submit an Enrollment Worksheet for continuation of benefits to the Employee Benefits Division within 60 days of the qualifying event, and
- You pay the required premiums as billed by the due date shown on the bill.

NOTE: Your right to elect continued coverage ends as soon as you become eligible for Medicare. However, continuation of coverage for your spouse or dependents is not affected by your Medicare eligibility.

QUALIFYING EVENT	PERSONS AFFECTED	LENGTH OF CONTINUATION OF COVERAGE
Termination of employee's employment (other than for gross misconduct)	Employee Spouse Dependent Child(ren)	18 months or until eligible for coverage elsewhere, including Medicare, ¹ whichever occurs first
Lay-off or resignation of employee	Employee Spouse Dependent Child(ren)	18 months or until eligible for coverage elsewhere, including Medicare, ¹ whichever occurs first
Reduction of employee's work hours (less than 50% time)	Employee Spouse Dependent Child(ren)	18 months or until eligible for coverage elsewhere, including Medicare, ¹ whichever occurs first
Birth of employee's child or legal adoption [†]	Dependent Child ²	Dependent child may be added to existing COBRA coverage ²
Employee's or retiree's dependent child turns 19 and is not a full-time student	Child	36 months or until eligible for coverage elsewhere, including Medicare, ¹ whichever occurs first

¹If you are enrolled in Medicare Parts A&B prior to leaving State service, you are entitled to elect continued coverage at the full COBRA rate. If you become entitled to Medicare while on COBRA, you will not be able to continue your coverage after your entitlement date. If you have dependents on your coverage when you become entitled to Medicare, your dependents may elect to continue their coverage on COBRA.

²Please note that a qualified beneficiary who is already in COBRA may add a new spouse to COBRA coverage. However, the new spouse does not gain or have his/her own COBRA rights. The new spouse would only have COBRA coverage the same time period as the existing beneficiary.

CONTINUA-
TION OF
COVERAGE/
LEAVE OF
ABSENCE/
COBRA

QUALIFYING EVENT	PERSONS AFFECTED	LENGTH OF CONTINUATION OF COVERAGE
Employee's or retiree's dependent child over 19 ceases to be a full-time student or turns 25, whichever occurs first	Child	36 months or until eligible for coverage elsewhere, including Medicare, [†] whichever occurs first
Death of State employee or retiree	Spouse Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare, [†] whichever occurs first
Election of Medicare as primary coverage by the State employee, and spouse or dependent children are not eligible for Medicare	Spouse Dependent Child(ren)	36 months or until eligible for coverage elsewhere, including Medicare, whichever occurs first
Divorce or legal separation from employee or retiree	Legally-Separated Spouse Former Spouse Dependent Child(ren)	Indefinitely or until eligible for coverage elsewhere, including Medicare and remarriage
Total and Permanent Disability of employee (as defined by the Social Security Act) within the first 60 days of COBRA coverage [†]	Employee [†] Spouse Dependent Child(ren)	The 18 months of coverage can be extended to 29 months <u>at increased premiums equal to 150% of usual premiums.</u> [†]

[†] This coverage has been mandated by the Health Insurance Portability and Accountability Act of 1996.

***NOTE: If a surviving spouse of a State employee will receive a monthly pension through the Maryland Retirement and Pension Systems under Retirement Options 2, 3, 5, or 6, and the deceased employee met certain age and service requirements, it is not necessary to apply for continuation of coverage under these provisions. The surviving spouse must be the retirement beneficiary.**

To enroll in COBRA, you must complete and sign a COBRA/LAWP Enrollment Worksheet and return it to the Employee Benefits Division within 60 days of the qualifying event. You then will be billed by the Employee Benefits Division for Continuation of Coverage premiums. These bills are in the form of pre-printed coupons for each month of coverage. The COBRA participant must certify that the participant is not covered, and is not eligible to be covered, under another group health plan.

If you do not elect COBRA during the required 60 day election time frame, or if the initial premium is not received within the required 45 day time frame, or if any required premium payment is not received within 30 days of the date due, you will be considered to have irrevocably waived all benefits available under COBRA regulations. COBRA benefits cannot be reinstated.

Conversion Privilege: When Active, LAW, or COBRA eligibility ends, and you have exhausted the continuation of coverage options available as described above, you may be eligible to convert your coverage over to a non-group health insurance policy, billed directly through the health care plan. To qualify for the conversion privilege, you must request conversion of coverage through your health care provider within 60 days of the qualifying event. You or your eligible dependents will be billed directly at the applicable non-group rate by the health care provider.



CONTINUA- TION OF COVERAGE/ LEAVE OF ABSENCE/ COBRA



NOTE: You must remove your ex-spouse and ineligible dependents from your coverage at the time of the divorce. Failure to do so may result in disciplinary action, termination of employment, and/or criminal prosecution. Your ex-spouse and and ineligible dependents are eligible for continuation coverage under COBRA. You will be charged the full individual premium for each month of coverage of an ineligible dependent and/or a former spouse.

Certificates of Coverage and the Health Insurance Portability and Accountability Act of 1996 (HIPAA): A new federal law, HIPAA, requires employers to provide certificates of coverage to all former employees, who then can give the certificates to their new employers. Some employer health plans have pre-existing condition exclusions, preventing immediate health insurance coverage for new employees. Certificates of coverage help reduce or eliminate the pre-existing condition exclusions under the new health plan. If you or your dependents obtain new employment, you may request a certificate of coverage from the State which describes the length and types of coverage (i.e., medical, dental, etc.) you and your dependents had under the State program. Please fill out and mail the following form (on page 77) to receive your certificates of coverage.

PRIVACY NOTICE

In its role as the administrator of the State of Maryland Employees' and Retirees' Health and Welfare Benefits Plan, the Department of Budget & Management, Office of Personnel Services and Benefits, Employee Benefits Division, will have access to some non-public personal health information of enrolled participants in the Plan. We require this information for enrollment, reviews and appeals, claims and administrative audits, fraud investigations, regulatory compliance and quality control purposes. This information is protected and kept confidential through the use of physical, electronic and procedural security safeguards. The State of Maryland does not disclose any personal information unless permitted or required by law and for the purposes listed above. We require any business associate, consultant, contractor, or other State agency which is granted access to this information to maintain security standards and to protect the confidentiality of this information as well. We do not disclose such information to third parties for other reasons unless we have legal authorization to do so. As the individual who is the subject of any information, you have the right to request to review the information, to request an amendment to correct the information, and to request a list of any disclosures of health information about you. Please contact the Employee Benefits Division for more information.

Questions?

If you have any questions about COBRA or Continuation of Coverage or HIPAA, please see your Agency Benefits Coordinator for more information.

Important Notice of Your Right to Documentation of Health Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) governs how health insurance plans handle pre-existing medical conditions when you are applying for health insurance coverage. Under the new law, your employer may require a Certificate of Health Coverage from your previous employer. If you or one of your dependents covered under the State Health Benefits Program is planning on changing jobs or already has done so, you may request a Certificate of Health Coverage that shows evidence of your prior health coverage with the State. If you buy health insurance other than through the State plan, a certificate of prior coverage may help you obtain coverage without a pre-existing condition exclusion.

You have a right to receive a certificate of prior health coverage as of July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for pre-existing conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate that documents your coverage under the State plan, complete the attached form and return it to:

Employee Benefits Division
301 West Preston Street, Room 510
Baltimore, Maryland 21201
Attn: HIPAA Certificates

For additional information, call (410) 767-4775.

This certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage with the State.

Request for Certificate of Health Coverage

Name of Participant: _____ Date: _____

Social Security Number of Employee/Retiree: _____

Address: _____

Daytime Telephone Number: _____

Name & Relationship of Any Dependents for Whom Certificates are Requested: _____

Their Address(es) if Different From Above: _____

RETIREMENT/ MEDICARE



RETIREMENT INFORMATION/MEDICARE

If you are thinking about retiring soon, you should be aware that there will be several changes in your health benefits. The major changes involves:

- Eligibility for State subsidy of your health benefits,
- Medicare eligibility,
- Term Life,
- PA&D plan, and
- Flexible Spending Accounts.

Eligibility for State subsidy of your health benefits: You may be eligible for State-subsidized health benefits when you retire from State service if you meet one of the following criteria:

- You leave State service with at least 16 years of creditable service,
- You retire directly from State service with a State retirement allowance and with at least 5 years of creditable service,
- You leave State service (deferring your retirement allowance) with at least 10 years of State creditable service and within 5 years of State normal retirement age, or
- You retire directly from State service with a disability retirement allowance.

A State employee who retires with 16 or more years of creditable service or who receives a disability benefit, regardless of years of service, receives the full State subsidy provided to an active employee.

A State retiree otherwise eligible for health benefits with at least five years of creditable service, but less than 16 years, receives a pro-rated subsidy. Therefore, if you have between five and 16 years of service, you will pay a pro-rated share of the State subsidy in addition to the regular premium. The retiree must pay the difference between the pro-rated subsidy and the entire premium cost.

Medicare Eligibility: Medicare is a federal health insurance program administered by the Social Security Administration for disabled individuals and those age 65 or older. As an active employee, you do not have to sign up for Medicare when you become eligible, and instead, may keep using the State health benefits as your only coverage. However, **when you retire**, and if you or your spouse are 65 or older or are certified as disabled, the person **MUST** sign up for both **Medicare Parts A & B** as soon as they are eligible due to age or disability. Medicare then becomes the primary coverage and State coverage must be supplemental to Medicare. Persons who are certified by the Maryland State Retirement Systems as disabled and eligible for a disability retirement must apply for Medicare Parts A & B within 2 years (24 months) of the disability retirement date. If Social Security denies Medicare coverage, you must provide the Social Security documentation to the State.

End Stage Renal Disease (ESRD): If you are certified by Medicare as eligible for ESRD coverage, you must sign up for both Medicare Parts A and B as soon as you are eligible.

NOTE: When you retire, if you or your spouse is eligible for Medicare due to age or disability, and fail to sign up for Parts A & B, the person will be responsible for the portion of claims costs that would have been paid by Medicare. Claim costs that would have been paid by Medicare are not covered by the State health plan.

Term Life Insurance: Active employees who were enrolled in the State Term Life Plan on or after January 1, 1995 will be allowed to continue their enrollment with the applicable State plan. Please see the Term Life Insurance section of this book for more information.



Personal Accidental Death and Dismemberment Insurance (PA&D): This plan is not available to State retirees.

Flexible Spending Accounts: Flexible Spending Accounts are not available to State retirees.

Beneficiaries of Deceased Retirees

If you choose **Retirement Option 2, 3, 5, or 6**, and you met the age and service requirements to be eligible for coverage, your spouse will continue to have a monthly pension check at the time of your death and will be able to continue subsidized health benefits. If you choose **Retirement Option 0, 1, 4, or 7** your spouse will only be eligible for non-subsidized benefits under COBRA for a limited period of time. The surviving spouse must be the sole primary retirement beneficiary to continue coverage.

Eligibility of Optional Retirement Program (ORP) Retirees

There are special rules governing the eligibility and costs of health benefits for Optional Retirement Program (ORP) Retirees (including Teachers Insurance and Annuity Association - College Retirement Equities Fund (TIAA-CREF), Valic, Aetna, and American Century):

- ORP retirees are eligible to participate in the State Employees Benefits Program, if:
 1. they retired directly from and had at least 5 years of State service with a State institution of higher education; or
 2. they ended State service with a Maryland State institution of higher education with at least 10 years of service and were at least age 57; or
 3. ended service with a Maryland State institution of higher education with at least 16 years of service (effective October 1, 2001).
- ORP retirees with less than 16 full years of State service upon retirement receive a prorated State subsidy for their Individual coverage.
- The full State subsidy for Individual coverage is available to ORP retirees who have 16 or more years of State service.
- The spouse or dependent children of the retired ORP employee may continue to be covered under the retired employee's coverage, upon payment by the eligible retiree of the entire difference in premium costs for the higher level of coverage, for ORP retirees with less than 25 years of State service.
- ORP retirees with 25 or more years of State service receive the full State subsidy for health benefits for their eligible dependents.
- The retiree's Agency Benefits Coordinator must forward the Benefits Enrollment Worksheet and attach a letter certifying the total number of years and months of service, and when the employee is retiring or leaving State service.
- ORP retirees who are not eligible to participate in the State Retirees Benefits Program may continue their benefits under COBRA for up to 18 months.
- Upon the death of an ORP retiree with 25 or more years of State service, the eligible dependents may continue with the same State subsidy. Upon the death of an ORP retiree with less than 25 years of State service, the eligible dependents may continue with no subsidy but only if the eligible dependents and must continue to receive a periodic distribution under an Optional Retirement Plan (effective October 1, 2001).

Questions?

If you have any questions about changes in coverage when you retire, please see your Agency Benefits Coordinator or contact the Employees Benefits Division at the phone number listed on the back cover of this book.

**END STAGE
RENAL
DISEASE**



END STAGE RENAL DISEASE

If you are certified by Medicare as eligible for ESRD coverage, you must sign up for both Medicare Parts A and B as soon as you are eligible. Medicare is a federal health insurance program for people age 65 or older, certain people with disabilities who are under 65, and people of any age who have permanent kidney failure (ESRD). Medicare is administered by the Social Security Administration. Individuals who have permanent kidney failure (ESRD), regardless of their age, can receive services through Medicare.

Your State Employees Health Plan will be your primary plan for the first 30 months of the ESRD. At the end of the 30 month period, Medicare becomes the primary payer. It is crucial that you apply for Medicare Parts A and B. If you do not sign up for both parts of Medicare, Hospital Insurance (Part A) and Medical Insurance (Part B), you will be responsible for paying all charges that Medicare would have covered.

When you are eligible for Medicare, please contact your local Social Security Office and request a Medicare Handbook. This handbook will provide you with information on Medicare Coverage for Kidney Dialysis and Kidney Transplant Services.

When you are no longer eligible for Medicare Part A and Part B for ESRD, please contact your local Social Security Office and request a cancellation of your Medicare coverage. After you receive your cancellation letter, please complete an Enrollment Worksheet to change your coverage level and forward it to the Employee Benefits Division.

**MARYLAND
RELAY**



MARYLAND RELAY

Maryland Relay gives people who are deaf or hard-of-hearing the ability to communicate with people who don't have such disabilities.

This service is available 24 hours a day, 7 days a week, with no restrictions on the length and number of calls placed by users. It can be reached from any phone or modem. There are no additional charges for local calls, and long distance calls are billed at reduced rates. Incoming or outgoing international calls are also available.

Call the Maryland Relay to connect with a Communications Assistant (CA). The CA will make the connection between the hearing person on the voice phone and the person with a hearing or speech disability on a text telephone (TT), also known as a TDD. The CA will type the conversation on the text telephone to one person and talk to the other person on the voice telephone.

HEALTH CARE FRAUD

Each year, health care fraud drains millions of dollars from employer-sponsored health plans, inevitably causing higher costs for all of us. As an employee or retiree enrolled in the State Health Benefits Program, you assume certain responsibilities:

- You are responsible for the accuracy of your benefits, including coverage levels, dependents, and payroll or retirement check deductions.
- You are responsible for the accuracy of your claim forms. If someone else files a claim on your behalf, you should review the form before signing it.
- You should never allow another person to seek medical treatment under your identity. If your plan card is lost, report the loss to the plan immediately. Plan phone numbers are located on the back cover of this book.
- You are required to assist the State in dealing with provider fraud by notifying the plan if a provider:
 - bills you or your health plan for services or treatments that you have never received,
 - asks you to sign a blank claim form, or
 - asks you to undergo tests that you feel are not needed.

NOTE: Health Care Fraud is a felony that can be prosecuted. Enrollment in or receipt of benefits to which you and/or your dependents are not entitled is considered fraud. If you willfully and knowingly engage in any activity intended to defraud the State Health Benefits Program, your benefits will be cancelled, you may be required to repay any claims that have been inappropriately paid, you may face charges for dismissal from State service, and you may face prosecution. If you attempt to add an ineligible dependent to your coverage, or if you fail to remove a dependent who is no longer eligible, you will be required to pay the full Individual premium for the ineligible person.

BENEFITS APPEAL PROCESS

The Employee Benefits Division strives to ensure proper coverage and claims payments under the benefits program. If you believe that your plan has denied payment of a covered benefit to which you are entitled, you should contact the plan. The plan will explain its appeal process and inform you of the steps you should take to file an appeal to the plan, and to the Maryland Insurance Administration (MIA) for HMO members.

Once you have exhausted all the plan's appeals and if you are not satisfied with the plan's decision following its review of your appeal, you may submit a written request for review by the Benefits Review Committee of the Employee Benefits Division. This request must be submitted within 30 days of your receipt of the plan's decision, and should describe the nature of your claim and the reasons why you believe that the claim has been improperly denied. The Benefits Review Committee should render a decision on your claim within 90 days of receipt. The decision of the Benefits Review Committee will be final. The address of the Benefits Review Committee is: Benefits Review Committee, c/o Employee Benefits Division, 301 West Preston Street, Room 510, Baltimore, Maryland 21201.



HEALTH
CARE
FRAUD



BENEFITS
APPEAL
PROCESS



Change of Name/Address Form-Active Employees

TO: Department of Budget and Management
Employee Benefits Division
301 W. Preston Street, Room 510
Baltimore, Maryland 21201

FROM: _____ (Employee Name)

RE: Change of Name and/or Address for Benefit Plans

Active Employee: _____ Contractual Employee: _____ Satellite Employee: _____

Please advise my benefit plans of my new name and/or address as follows:

EMPLOYEE SOCIAL SECURITY NUMBER: - -

EMPLOYEE NAME:

Old Name: _____
Last First M

I
New Name: _____
Last First MI

NEW ADDRESS: _____
Street

City or Town State Zip

NEW HOME PHONE: _____
Area Code Number

This form should be sent to the following benefit plans in which I am enrolled:

- _____ Name of Health Plan: _____
- _____ PCS Prescription Plan
- _____ United Concordia
- _____ Dental Benefit Providers
- _____ Term Life Insurance Plan
- _____ PA&D (Personal Accident and Dismemberment) Plan
- _____ Health/Day Care Spending Accounts

Employee Signature

Agency Benefit Coordinator Signature

Date

Date

Agency & Phone Number

NOTE: Payroll Change-of-Address Card **MUST** be sent to Central Payroll Bureau at the same time.

State of Maryland

Employee/Retiree Benefits Program Certification of Dependent Eligibility

Dependent children are covered through end of year in which they turn 19. Beyond that year, full-time student certification is required for dependents 20 to 25.

Employee to complete the following:

Employee/Retiree Name:	Employee/Retiree Social Security Number:
Dependents Name:	Dependents Date of Birth: Month _____ Day _____ Year _____
Dependents Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Employee:
Dependents Social Security Number:	Dependents Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
Do you provide 50% of the dependents support? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the dependent permanently reside with you? <input type="checkbox"/> Yes <input type="checkbox"/> No I hereby certify that the information contained on this form is correct to the best of my knowledge and authorize the release of any information requested with respect to this certification.	
_____ Signature of Employee/Retiree	_____ Daytime Telephone Number _____ Date

Student Certification: School Official to complete this section if dependent is eligible based on student status:

School Name:	School Address:
Beginning and ending date of current semester: _____ to _____	
Is this institution accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Credit hours per current semester or classroom hours per week: _____	
What is the student status as determined by the institution: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Is the student currently on summer break? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did the student attend spring semester preceding break? <input type="checkbox"/> Yes <input type="checkbox"/> No Is student enrolled for the fall semester? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I hereby certify that the above information is correct to the best of my knowledge.	
_____ Signature of School Official	_____ Daytime Telephone Number _____ Date

Disability Certification: dependents attending physician to complete this section if dependent is eligible based on disability:

Nature of disability:	Date disability began:
Did the dependents disability begin prior to the dependents 19th birthday, or 25th birthday while still a student? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I hereby certify that the above information is correct to the best of my knowledge. Attach appropriate documentation).	
_____ Signature of Physician	_____ Daytime Telephone Number _____ Date



State of Maryland

Employee/Dependent/Retiree
Claims Submission Form

Patient Name: _____

Subscriber's ID/SS #: _____

Patient's Date of Birth: _____

Provider Name & Credentials: _____

Check should be sent to: (Name and Address)

***** Please attach an itemized copy of the bill from your provider to this cover sheet (date of service, diagnosis, CPT code, patient name, patient date of birth, charges)**

Send claims to: APS
PO Box 1440
Rockville, Maryland 20849-1440

GLOSSARY

Allowed Amount: The maximum fee a health plan will pay for a covered service or treatment. The allowed amount is determined by each health plan.

Cafeteria Plans: Plans allowing employees to choose from a menu of one or more qualified benefits. Under Section 125 of the Internal Revenue Service Code, benefits from a cafeteria plan are not taxed to the employee who selects them.

CMS: Center for Medicaid and Medicare Services. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

COB: Coordination of benefits. If an employee, retiree, or eligible dependents are covered under more than one insurance plan, the insurance companies determine which coverage is primary. The employee's or retiree's primary coverage will pay its benefits first, without regard to other coverage.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985. This law amended by ERISA, the PHSA, and the tax code to require employers to offer the option of purchasing continued coverage to qualified beneficiaries who would otherwise lose group health insurance coverage as the result of a qualifying event. The federal statute which applies to the State of Maryland is the Public Health Service Act (PHSA).

Coinsurance: The portion of medical services that the employee must pay in addition to the deductible.

Copayment: The amount of money an employee, retiree, or covered dependent pays at the time service is rendered. This money goes directly to the health care provider. The amount of the copayment varies by plan.

Coverage, Limitations, Exclusions, or Preauthorization Requirements: The amount or extent to which any particular treatment or service is covered by a health plan.

Deductible: The amount of money an employee or retiree is required to pay before direct payment or reimbursement is available from the plan.

Dental Plan: A health plan that partially or fully reimburses employees and retirees for dental services.

Dental POS: A dental plan similar to a medical POS, allowing members to self-refer out-of-network for most services subject to higher fees. Braces must be in-network only.

DHMO: Dental Health Maintenance Organization. A plan similar to a medical HMO, but provides dental services. Participants can use only those designated dental providers approved by and registered with the DHMO.

ERISA: Employee Retirement Income Security Act of 1974. ERISA is the basic law designed to protect the rights of beneficiaries of employee benefit plans offered by private employers. The State Employees and Retirees Health Benefits Plan is not covered by ERISA.

Flexible Spending Account (FSA): A benefit option that reimburses employees for certain expenses they incur. Money is deducted from pay checks on a pre-tax basis. It most often covers reimbursements for medical expenses not covered under other insurance, or day care expenses for eligible children and adults.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law which requires employers to provide certificates of coverage to minimize pre-existing condition exclusions by next employer.

GLOSSARY

GLOSSARY

HMO: Health Maintenance Organization. A network of medical providers that offers medical care to participants. Participants receive all medical care through their HMO.

In-Network Service: Service provided by a participating provider, Primary Care Physician, or provider approved by the plan.

IPA: Independent Practice Association. A type of HMO consisting of coordinated groups of physicians practicing out of individual offices.

LAWP: Leave of Absence Without Pay. An employer approved period of leave during which the employee is not paid, but does not terminate State service. Any approved leave of absence of two pay periods or less is considered a short term LAWP. Any approved leave of absence more than two pay periods is considered a long term LAWP.

Medical Necessity: All health plans require that a service or treatment must be considered a medical necessity to be covered. The definition of medical necessity varies by plan. Please contact your plan to determine what types of treatment and service are considered medical necessities.

Medical Plan: A health plan that partially or fully reimburses employees or retirees for costs of personal injuries or illness.

Medicare: A federal health insurance program administered by the Social Security Administration for disabled individuals and those age 65 or older. Eligible Medicare participants must enroll in both Parts A and B, because the State plan is often the secondary payer, and will not cover expenses and claims covered by Medicare.

Network: A group of providers that have contracted with an insurance agency to provide services and treatment to individuals.

Open Enrollment Period: An annual period during which employees and retirees are given the option of enrolling in or changing one or more health care plans.

Out-of-Network Service: Service received from providers outside of the plan's network. Such services are subject to up-front deductibles and co-insurance.

Plan: A health care program offered by the State that partially pays or reimburses the employee or retiree for covered health care services or treatments.

Plan Year: The plan year for benefits begins January 1 and ends December 31 of each year.

POS: Point-of-Service. An HMO plan that allows members to self-refer out of the network for most services, subject to higher fees than if care were received from the HMO network. Excludes preventive services.

PPO: Preferred Provider Organization. A network of medical care providers that provides various medical care services to covered employees and retirees for specified fees. Although fees charged by PPO providers are usually less than those charged by non-PPO providers, the employee or retiree may seek treatment from any provider.

Preauthorization: A Plan's prior approval is required for treatments or services.

Premium: The amount of money an employee or retiree pays for insurance coverage. A premium does not include additional copayments or deductibles incurred for treatment.

GLOSSARY

Primary Care Physician (PCP): The health care professional who belongs to an HMO or POS network and provides primary care for employees, retirees, or covered dependents. An employee or retiree must select a PCP when using an HMO or POS medical plan.

Primary Dental Office (PDO): The health care professional who belongs to an HMO or POS network and provides primary care for employees, retirees, or covered dependents. An employee or retiree must select a PDO when using a dental HMO or POS plan.

Provider: Any approved health care professional who provides treatment or services.

Qualified Medical Child Support Orders (QMCSO): A court order that requires a parent to provide health care coverage for dependent children.

Qualifying Event: An event such as marriage, divorce, or the birth of a child, that allows a change in health care coverage outside of the Open Enrollment period.

Retroactive Coverage: The process of paying back premiums to back date coverage to the date of the qualifying event.

State Subsidy: The portion of your insurance premium(s) that the State pays as a benefit to employees and retirees.

Summary Plan Description: A report describing the contents of a plan which must be provided to the plan participant.

Term Life Insurance: Insurance that provides death benefit coverage for a specified period, without permanent policy benefits such as cash or loan value.

TIAA-CREF: Teachers Insurance and Annuity Association - College Retirement Equities Fund. A nationwide retirement and annuity association set up for university and college employees.

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2003 State of Maryland Premium Rate Table

Medical Plans Name of Plan	Biweekly Medical Premiums			Monthly Medical Premiums		
	1 Person	2 People	3 + People	1 Person	2 People	3 + People
Blue Cross Blue Shield (PPO)	31.64	56.95	79.11	63.28	113.91	158.22
MLH-Eagle (PPO)	32.56	58.62	81.41	65.12	117.23	162.82
Aetna Quality (POS)	17.51	31.52	43.78	35.02	63.04	87.56
BCBS - Maryland (POS)	19.17	34.50	47.92	38.34	69.00	95.84
M.D.IPA Preferred (POS)	18.46	33.23	46.16	36.92	66.46	92.31
Blue Choice (HMO)	16.90	35.47	43.94	33.80	70.93	87.88
Kaiser Permanente (HMO)	15.79	31.57	39.55	31.58	63.15	79.10
Optimum Choice (HMO)	15.87	33.02	39.36	31.75	66.03	78.72

Prescription Plan Coverage Level	Biweekly Prescription Premium	Monthly Prescription Premium
Employee Only	\$ 16.04	\$ 32.07
Employee & One Child	\$ 21.31	\$ 42.61
Employee & Spouse	\$ 26.61	\$ 53.22
Employee & 2 or More	\$ 32.06	\$ 64.13

Dental Plans Coverage Level	Biweekly Dental Premiums			Monthly Dental Premiums		
	Dental Benefit Providers DHMO	United Concordia DHMO	United Concordia DPOS	Dental Benefit Providers DHMO	United Concordia DHMO	United Concordia DPOS
Employee Only	\$ 3.41	\$ 3.25	\$ 4.38	\$ 6.81	\$ 6.50	\$ 8.77
Employee & One Child	\$ 6.81	\$ 5.65	\$ 7.63	\$ 13.62	\$ 11.31	\$ 15.26
Employee & Spouse	\$ 7.49	\$ 6.50	\$ 8.84	\$ 14.98	\$ 13.00	\$ 17.68
Employee & 2 or More	\$ 11.92	\$ 9.14	\$ 12.32	\$ 23.84	\$ 18.28	\$ 24.65

The Term Life Insurance premiums for 2003 are located on the inside front cover of this book. The Term Life Insurance Plan is with Standard Insurance Company effective January 1, 2003.

The AD&D premiums for 2003 are located on the inside front cover of this book. The AD&D plan is with the Metropolitan Life Insurance Company effective January 1, 2003.

PLAN PHONE NUMBERS

Medical Plans

CareFirst Blue Cross Blue Shield PPO

- State Operations Center
(410) 581-3601 (Baltimore)
1-800-225-0131 (Outside Baltimore)
(410) 998-7338 TTY/TDD
- Open Enrollment Hotlines
(410) 581-3602 (Baltimore)
1-800-852-4463 (Outside Baltimore)

Website:

www.carefirst.com/statemd

CareFirst Blue Cross Blue Shield Maryland POS

- State Operations Center
(410) 581-0021 (Baltimore)
1-800-203-2763 (Outside Baltimore)
(410) 998-7338 TTY/TDD
- Open Enrollment Hotlines
(410) 581-3602 (Baltimore)
1-800-852-4463 (Outside Baltimore)

Website:

www.carefirst.com/statemd

CareFirst Blue Cross Blue Shield BlueChoice HMO

(410) 654-8675 (Baltimore)
1-800-445-6036 (Within Maryland)
(410) 605-2492 TTY/TDD
1-800-828-3196 TTY/TDD

Website:

www.carefirst.com/statemd

Kaiser Permanente HMO

1-800-777-7902 (Baltimore)
(443) 663-6181 (Baltimore)
(301) 468-6000 (Washington)
1-800-368-5784 (Washington)
(410) 339-5545 TTY/TDD (Baltimore)
(301) 816-6344 TTY/TDD (Washington)

Website:

www.KaiserPermanente.org

Aetna QPOS

1-888-287-4296
(1-888-287-4296 TTY/TDD)

Website: www.aetnaushc.com

MLH-EAGLE PPO (MAMSI)

1-800-447-6267
(301) 309-1710 TTY/TDD

Website: www.Mamsi.com

M.D. IPA Preferred POS (MAMSI)

1-800-447-6267
(301) 309-1710 TTY/TDD

Website: www.Mamsi.com

Optimum Choice HMO (MAMSI)

1-800-447-6267
(301) 309-1710 TTY/TDD

Website: www.Mamsi.com

Prescription Plan

AdvancePCS

1-800-345-9384

Website: <http://maryland.buildingbetterhealth.com>

Hyperlink: <http://opsb.state.md.us/empbenefits/benefits.htm>

Dental Plans

Dental Benefits Providers DHMO

1-877-566-3562

Website: www.dbp-inc.com

United Concordia DHMO and DPOS

1-888-MD-TEETH

(1-888-638-3384)

Website: www.ucci.com

(click on MD State icon)

Mental Health/Substance Abuse Plan

APS Healthcare, Inc. (APS)

1-877-239-1458

Website: www.APSHelpLink.com

MD State Code: SOM2002

Long Term Care Plan

Unum Life Insurance Co.

1-800-227-4165

Website: www.unums.com/enroll/maryland

Accidental Death and Dismemberment

Metropolitan Life Insurance Co.

1-888-842-2757

Website: www.metlife.com

Term Life Insurance Plan

Standard Insurance Co.

1-888-246-9002

Website: www.standard.com/mybenefits/maryland

Flexible Spending Account Administration

Erisa Administrative Services

1-888-966-FLEX (3539)

Website: www.flexmd.cserisa.com

Employee Benefits Division

301 West Preston Street, Room 510
Baltimore, MD 21201

(410) 767-4775

1-800-30-STATE (1-800-307-8283)

Website: <http://www.opsb.state.md.us/empbenefits/benefits.htm>